ELDER ABUSE: A DECADE OF SHAME AND INACTION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MAY 1, 1990

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CONTENTS

MEMBERS' OPENING STATEMENTS

Page
Chairman Edward R. Roybal 1
Ron Wyden 5
Mary Rose Oakar 5
Thomas J. Downey 18
Harold E. Ford 21
Ralph Regula 23
Helen Delich Bentley 28
Jim Jontz 29
Claudine Schneider 29
Bill Richardson 29

CHRONOLOGICAL LIST OF WITNESSES

Mr. Jones, victim of physical abuse, Cambridge, Massachusetts, accompanied by Scott Harshbarger, District Attorney, Cambridge, Middlesex County, Massachusetts 32
Jan McLaughlin, Program Director, Services to Aged and Disabled, Texas Department of Human Services, Houston, Texas, on behalf of Mr. Hernandez, son of elder abuse victim, Houston, Texas 50
Sue M. Parkins, M.D., F.A.C.E.P., Medical Director, Adult Protection Team, St. Vincent Medical Center, Toledo, Ohio 53
Toshio Tatara, Ph.D., Director, Research and Demonstration Department, American Public Welfare Association, and Director, National Aging Resource Center on Elder Abuse 62
Michael F. Coonan, Director, Center for Advocacy/Ombudsman Services, Sacramento, CA, prepared statement 87

APPENDIX

Appendix I. "Elder Abuse: A Decade of Shame and Inaction," Executive Summary and tables from the Report of April 1990, submitted for the hearing record by Chairman Edward R. Roybal 93
Appendix II. Supplemental material submitted for the hearing record by Scott Harshbarger, District Attorney, Cambridge, Middlesex County, Massachusetts:
    The Middlesex County District Attorney's Action Plan for Crimes Against the Elderly 119
    Crimes Against the Elderly: Preliminary Findings 182
    Elder Protective Services Program Report for Fiscal Year 1989 ....
Appendix III. Supplemental material submitted for the hearing record by Toshio Tatara, Director, Research and Demonstration Department, American Public Welfare Association, and Director, National Aging Resource Center on Elder Abuse:
    Summaries of National Elderly Abuse Data: An Explanatory Study of State Statistics 308
Appendix IV. Additional material received for the hearing record:
    Rosalie S. Wolf, President, National Committee for the Prevention of Elder Abuse, Worcester, Massachusetts, letter and prepared statement with attachment 360
    Donald R. Smith, Commissioner, Department on Aging and Disability, City of Chicago, Chicago, Illinois, letter and prepared statement 371

Page

Appendix IV. Additional material received for the hearing record—Continued
- John Rother, Division Director, Legislation, Research, and Public Safety, American Association of Retired Persons, Washington, DC, letter and prepared statement 378
- Ray Garcia, Director, Bureau of Program Planning and Development, County of Los Angeles Department of Public Social Services, El Monte, California, letter and prepared statement 382
- Prema Mathai-Davis, Commissioner, New York City Department for the Aging, prepared statement 386
- "Guidelines and Commentary for Legislation to Prohibit Patient and Resident Abuse," By the National Association of Attorneys General and National Association of Medicaid Fraud Control Units 396
- Allen R. Bares, State Senator, President of the Senate, State of Louisiana letter to then Chairman Claude Pepper, dated July 21, 1988, with attachments, concerning the status of funding for adult protective services in Louisiana's 1988-89 proposed budget 411

ELDER ABUSE: A DECADE OF SHAME AND INACTION

TUESDAY, MAY 1, 1990

U.S. House of Representatives,
Select Committee on Aging,
Subcommittee on Health and Long-Term Care,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in Room 311, Cannon House Office Building, Hon. Edward R. Roybal (chairman of the subcommittee) presiding.

Members present: Representatives Roybal, Ford, Oakar, Wyden, Skelton, Hertel, Borski, Sisisky, Richardson, Jontz, Schneider, and Bentley.

Staff present: Kathleen Gardner Cravedi, Staff Director, and Melanie Modlin, Assistant Staff Director.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Chairman Roybal. Ladies and gentlemen, today we will hear cases of adult children kicking and hitting their parents; attacking them with knitting needles and knives; or stealing their Social Security and retirement income checks; and shamelessly neglecting their basic rights. Such abuse flies in the face of all that is good and decent. It confounds the Commandment, "Honor thy father and mother." The general public finds it hard to believe that it even exists, and victims are reluctant to admit that their loved ones are abusers. That is why elder abuse remains a hidden problem.

In fact, according to a report I'm releasing today, only one in eight cases of elder abuse gets reported, and over 1.5 million, or about 5 percent of the elderly population, are abused by their loved ones annually. We surveyed all State Human Services Departments and we found the following:

We found, first of all, that abuse of the elderly is increasing. In fact, it's up 50 percent from 1980.

We found that 43 States had enacted Adult Protective Services laws by 1990. And that's on the positive side, and that is good. But we found that only 16 States had such laws in place in 1980. States have enacted these statutes in anticipation of Federal funding, which has yet to be appropriated.

States spent only about $45 per child resident for Child Protective Services in 1989. But the truth of the matter is, these same States spent only $3 on the average for elder abuse victims.

In 1980, when we issued the first report on elder abuse, we recommended we enact elder abuse legislation identical to the successful Child Abuse Prevention Act of 1974. A decade has passed, and we have yet to do that. This tragic, helpless population deserves the assistance that this bill would give them.

I am pleased to release today a report that has taken a long time to compile. It is a report by the Select Committee on Aging which deals with the problem of elder abuse, and it is called "Elder Abuse: A Decade of Shame and Inaction." This report will be made available to anyone upon request and we'll also be sending this report to the various organizations throughout the country.

I hope that this report will serve as the necessary vehicle to accomplish some of the things that this report recommends get done.

[The prepared statement of Chairman Roybal follows:]

STATEMENT OF THE HONORABLE EDWARD R. ROYBAL
CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
U.S. HOUSE SELECT COMMITTEE ON AGING
"ELDER ABUSE: A DECADE OF SHAME AND INACTION"

LADIES AND GENTLEMEN, MEMBERS OF THE SUBCOMMITTEE. I WANT TO WELCOME YOU TO TODAY'S HEARING ON ELDER ABUSE -- THE PHYSICAL, FINANCIAL AND PSYCHOLOGICAL ABUSE OF SENIOR CITIZENS IN THEIR OWN HOMES BY LOVED ONES AND OTHERS ENTRUSTED WITH THEIR CARE.

ELDER ABUSE IS NOT A PRETTY SUBJECT. TODAY WE'LL HEAR CASES OF ADULT CHILDREN KICKING AND HITTING THEIR PARENTS, ATTACKING THEM WITH KNITTING NEEDLES AND KNIVES, STEALING THEIR SOCIAL SECURITY AND RETIREMENT CHECKS, AND SHAMELESSLY NEGLECTING THESE ELDERLY RELATIVES' BASIC HUMAN NEEDS.

ELDER ABUSE FLIES IN THE FACE OF ALL THAT IS GOOD AND DECENT. IT CONFOUNDS THE COMMANDMENT, "HONOR THY FATHER AND MOTHER." THE GENERAL PUBLIC DOES NOT WANT TO BELIEVE IT EXISTS AND MOST ELDER ABUSE VICTIMS THEMSELVES ARE RELUCTANT TO ADMIT THAT THEIR LOVED ONES ARE THEIR ABUSERS. THAT'S WHY ELDER ABUSE REMAINS A HIDDEN PROBLEM.

IN FACT, ACCORDING TO SUBCOMMITTEE DATA, ONLY 1 IN 8 CASES OF ELDER ABUSE COMES TO THE ATTENTION OF APPROPRIATE AUTHORITIES. 1.5 MILLION OLDER AMERICANS, OR 5% OF THE ELDERLY, ARE VICTIMS OF ELDER ABUSE EACH YEAR -- UP 50% FROM 1980.

TODAY, I AM RELEASING A REPORT BY THE SUBCOMMITTEE, "ELDER ABUSE: A DECADE OF SHAME AND INACTION," WHICH CONTAINS MANY MORE DISTURBING FACTS. WE SURVEYED STATE HUMAN SERVICES DEPARTMENTS AROUND THE NATION REGARDING THEIR EXPERIENCES WITH ELDER ABUSE AND WERE ABLE TO REACH A NUMBER OF CONCLUSIONS. FOR EXAMPLE:

- ABUSE OF THE ELDERLY IS INCREASING ALL OVER THE NATION. ABOUT 5 PERCENT OF THE NATION'S ELDERLY MAY BE VICTIMS OF ABUSE, FROM MODERATE TO SEVERE, EACH YEAR. BECAUSE ELDER ABUSE AFFECTS SOME 1.5 MILLION ANNUALLY, THIS MEANS THAT ABOUT 1 OF EVERY 20 OLDER AMERICANS MAY FALL PREY TO ELDER ABUSE EACH YEAR.

- ELDER ABUSE CASES ARE LESS LIKELY TO BE REPORTED TODAY THAN IN PAST YEARS. WHILE 1 OF EVERY 5 CASES OF ELDER ABUSE WAS REPORTED IN 1980, 1 OF EVERY 8 CASES IS NOW REPORTED, ACCORDING TO DATA IN OUR NEW REPORT. AND, ELDER ABUSE IS FAR LESS LIKELY TO BE REPORTED THAN CHILD ABUSE. (ONE OF EVERY 3 CHILD ABUSE CASES IS REPORTED TO APPROPRIATE AUTHORITIES.)

- THE MAJORITY OF STATES -- FOUR FIFTHS, OR 43 STATES (INCLUDING THE DISTRICT OF COLUMBIA) -- HAVE ENACTED STATE STATUTES OR ADULT PROTECTIVE SERVICE LAWS MAKING IT MANDATORY THAT CASES OF ELDER ABUSE BE REPORTED BY MEMBERS OF CERTAIN PROFESSIONS, LIKE DOCTORS AND SOCIAL WORKERS. THIS IS A SIGNIFICANT INCREASE OVER 1980, WHEN ONLY 16 STATES HAD SUCH LAWS, AND 1984 WHEN 38 STATES (INCLUDING THE DISTRICT OF COLUMBIA) HAD ENACTED SUCH PROVISIONS. HOWEVER, THE SUBCOMMITTEE HAS FOUND THAT STATE IMPLEMENTATION AND ENFORCEMENT OF THESE LAWS WILL

NOT BE ACCOMPLISHED IN ANY MEANINGFUL WAY UNTIL WE ENACT FEDERAL LEGISLATION PROVIDING FUNDING INCENTIVES TO THE STATES, AS WE ALREADY DO FOR CHILD ABUSE. BECAUSE SUCH LEGISLATION HAS NOT BEEN APPROVED, MOST STATES ARE HARD PRESSED TO CARRY OUT THESE MANDATES. SOME, SUCH AS LOUISIANA, HAVE SIMPLY STOPPED PROVIDING ELDER ABUSE PROTECTIVE SERVICES ALTOGETHER.

- FUNDING FOR ELDER ABUSE PREVENTION, DETECTION AND TREATMENT IS VERY SPARSE INDEED. SINCE 1980, THE PRIMARY SOURCE OF FEDERAL FUNDING, THE SOCIAL SERVICES BLOCK GRANT, HAS BEEN CUT NEARLY ONE THIRD BY DIRECT CUTS AND INFLATION. FACED WITH THE CLEAR NEED TO DO MORE, THE FEDERAL GOVERNMENT IS DOING CONSIDERABLY LESS.

- SUBCOMMITTEE FINDINGS REVEAL THAT THE STATES SPEND ONLY ABOUT $45.03 PER CHILD RESIDENT FOR CHILD PROTECTIVE SERVICES IN 1989. AS PATHETIC AS THAT IS, IT'S SHAMEFUL THAT THEY ALLOTTED ONLY $3.80 PER ELDERLY RESIDENT FOR PROTECTIVE SERVICES IN 1989.

I HAVE BEEN TOLD BY OFFICIALS IN MY OWN STATE OF CALIFORNIA THAT ALTHOUGH THE STATE MANDATES THAT ELDER ABUSE BE REPORTED, THE FUNDING TO IDENTIFY AND ASSIST SUCH VICTIMS IS NEARLY NON-EXISTENT. A BILL PASSED BY THE STATE LEGISLATURE TO PROVIDE THE FUNDS TO ASSIST ELDER ABUSE VICTIMS HAS TWICE BEEN VETOED BY THE GOVERNOR. WHILE IT IS SHAMEFUL THAT CALIFORNIA SPENDS ONLY $59 PER CHILD RESIDENT ANNUALLY FOR PROTECTIVE SERVICES, IT IS A DISGRACE THAT THE STATE DEVOTES LESS THAN $3 PER ELDERLY PERSON FOR PROTECTIVE SERVICES FOR THAT AGE GROUP. CALIFORNIA IS HOME FOR 10 PERCENT OF THE NATION'S ELDERLY.

ON THE BASIS OF THE STATISTICS GATHERED BY THE SUBCOMMITTEE, AND OTHERS COMPILED BY SUCH GROUPS AS THE AMERICAN PUBLIC WELFARE ASSOCIATION, A REPRESENTATIVE OF WHICH WILL TESTIFY AT THIS HEARING, THE OBVIOUS QUESTION IS, "WHAT CAN THE FEDERAL GOVERNMENT DO TO HELP SENIORS LIVE SAFELY IN THEIR OWN HOMES?"

IN REVIEWING THE HISTORY OF DOMESTIC ABUSE IN THE UNITED STATES, THE SUBCOMMITTEE HAS FOUND THAT FEDERAL LEGISLATION IN THE AREA OF CHILD ABUSE HAS BROUGHT GOOD RESULTS AT A REASONABLE PRICE, ENCOURAGING THE STATES TO ENACT REGULATORY REFORM TO PREVENT AND IDENTIFY THE ABUSE OF CHILDREN. WE NEED TO DO SOMETHING SIMILAR FOR OUR ELDERLY. MY COLLEAGUE ON THE SUBCOMMITTEE, THE HONORABLE MARY ROSE OAKAR OF OHIO, HAS INTRODUCED A BILL, H.R. 220, OF WHICH I'M PROUD TO BE A COSPONSOR, TO ADDRESS THIS ISSUE. THE BILL WOULD CREATE A NATIONAL CENTER ON ELDER ABUSE UNDER THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO COMPILE, PUBLISH AND DISSEMINATE INFORMATION TO COMMUNITIES ACROSS THE COUNTRY. IT WOULD PROVIDE FEDERAL MATCHING FUNDS TO STATES WITH ELDER ABUSE PROGRAMS IN PLACE AND DISTRIBUTE MONIES FOR NEW PROGRAMS TO STATES THAT MEET CERTAIN CONDITIONS, LIKE PROVIDING IMMUNITY FROM PROSECUTION TO PERSONS REPORTING SUSPECTED CASES OF ELDER ABUSE.

AS WE WILL HEAR TODAY FROM OUR WITNESSES, ELDER ABUSE IS A TERRIBLE PROBLEM THAT CAN HAVE TRAGIC CONSEQUENCES. THIS SORT OF THING SHOULD NOT BE ALLOWED TO OCCUR UNCHECKED IN THIS GREAT COUNTRY BUT TOO OFTEN, GIVEN THE SHORTAGE OF RESOURCES DEVOTED TO ADULT PROTECTIVE SERVICES, THAT'S EXACTLY WHAT HAPPENS.

I LOOK FORWARD TO THE TESTIMONY THAT WILL BE PRESENTED TODAY AND I THANK ALL OF YOU FOR COMING. I AM HOPEFUL THAT TODAY'S HEARING WILL HELP STIMULATE THE SPECIAL ATTENTION NEEDED TO HELP, AT LAST, THOSE TRAGICALLY HELPLESS PEOPLE WHO ARE BEING ABUSED. THANK YOU.

Chairman **Roybal.** The Chair will now recognize Mr. Wyden.

STATEMENT OF REPRESENTATIVE RON WYDEN

Mr. **Wyden.** Thank you very much, Mr. Chairman. I want to commend you and our colleague, Congresswoman Oakar, for your outstanding work in this area, and this report in particular.

It's quite clear that the findings of this report reveal a frightening pattern of abuse against some of our most vulnerable and frail citizens. A million and a half elders are abused each year, and the Federal Government couldn't care less.

A caring government, for example, wouldn't cut the primary source of Federal funding for State Protective Services, the Social Services Block Grant, by nearly one-third.

A caring government wouldn't sit by while the gap between the number of cases of abuse and the number of cases where it's reported actually grows.

And a caring government certainly would not sit by while very modest initiatives could be implemented, such as the establishment of the toll free line.

In our home State of Oregon, we saw that there was a significant increase in number of cases, and yet there was less and less reporting by many programs simply because they didn't have the resources to put into place the protective services that are needed.

So I'm very pleased that we're going forward with this study. It's quite clear to me that we don't do enough for kids in this country, but this report shows that we're doing even less for the frail elderly. That's unacceptable. And with the good work of you, Mr. Chairman, our colleague, Congresswoman Oakar, we can turn this around.

Chairman **Roybal.** Thank you, Mr. Wyden. The Chair would like to now recognize a Member of the House of Representatives that has been most active in this particular field. It is my pleasure to recognize Congresswoman Oakar.

STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Ms. **Oakar.** Thank you, Mr. Chairman.

I want to thank you and your excellent staff for providing the leadership in doing the second comprehensive report on elder abuse that has documented and researched every State in the Union. It's really an extensive work. And it's the only work I know of, outside of the one that you and Senator Pepper and others did 10 years ago.

The fact is you're to be complimented. And isn't it interesting that 10 years later we have an increase that's documented. And as you mentioned, Mr. Chairman, only one out of eight cases are reported. But we have a documentation that shows that we've gone up from 1 million older people to 1.5 million older people who are victimized every year.

Mr. Chairman, I think we have to ask why 1 in 20 older Americans are victimized. And I think we have to get to the root of the issue.

One reason we know is that the caregivers who are the most likely individuals to victimize older people are essentially the children, with few exceptions to that rule. Why is it that children are abusing their parents, or their grandparents?

One reason, and I think we have to acknowledge this, is the fact that we are the only industrialized country—outside of South Africa—that does not provide comprehensive health coverage, including long-term care—which I know, Mr. Chairman, you and others are sponsors of bills, including myself—that would provide congregate services.

If you have a mother with Alzheimer's disease and you have to go out and work, it's very difficult for you to care for that person without services to help you and without respite care for the families. So the stress involved in not having the avenues of help that are very basic and, frankly, in some areas is very simple, is one of the reasons for elder abuse. It's not excusable that kids do this. But that is one of the reasons.

The second major reason found in the report that I think we ought to be four square and honest about is the increase in alcohol and drug abuse in this country. And we ought not to leave out alcoholism. That's still the number one drug in the country. And when young people or middle-aged people are drunk and they have the stress of caring for somebody that they love and can't get the services, let alone have this addictive problem, they are very likely to victimize their loved ones.

We do not have insurance coverage, by and large, and we don't even have a nickel for alcoholism in the Omnibus Drug Act. We do not have the coverage for treatment that is very, very important. And we have not had the guts as a Nation to talk about that as an issue and to make it a policy.

The third thing, Mr. Chairman, that I think would certainly be helpful, is to pass the modest bill that I introduced 10 years ago related to elder abuse. It's patterned after the Child Abuse Act that was passed in 1974. You are the major cosponsor, Mr. Chairman, which I'm deeply grateful for. And essentially what this would do would be to provide the clearinghouse of data needed, the documentation needed. It would provide the seed money that would give States the incentive to do more on a local level so that these people can get out of these horrible situations, just as we are able to get children out of these situations when they are abused—not in all cases, but at least there's a national policy that says, we want to do this.

And the third area is we would require reporting, but we would grant immunity to people who want to report. Very often people witness or see parents coming into emergency rooms, or their next door neighbors being beat up, but they are sometimes limited from reporting because we still do not have a national policy that grants immunity to these people.

There are other things in H.R. 220—the cost of the bill is $10 million. You know, that's, I guess, what is so frustrating. That, by way of comparison, is minuscule in terms of what we can do. So let's pass a long-term care bill. Let's pass H.R. 220, and let's really have a national conscience about this problem.

Thank you, Mr. Chairman, and my colleagues, and thanks to the witnesses.

[The bill, H.R. 220, and Summary, follows:]

101st CONGRESS
1st Session

H. R. 220

To provide financial assistance for programs for the prevention, identification, and treatment of elder abuse, neglect, and exploitation, to establish a National Center on Elder Abuse, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

January 3, 1989

Mr. Oakar introduced the following bill; which was referred jointly to the Committees on Education and Labor and Energy and Commerce

---

A BILL

To provide financial assistance for programs for the prevention, identification, and treatment of elder abuse, neglect, and exploitation, to establish a National Center on Elder Abuse, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

Section 1. This Act may be cited as the "Prevention, Identification, and Treatment of Elder Abuse Act of 1989.".

NATIONAL CENTER ON ADULT ABUSE

Sec. 2. (a) The Secretary of Health and Human Services (hereinafter referred to in this Act as "Secretary") shall establish a program within the Administration on Aging, to be known as the National Center on Elder Abuse (hereinafter referred to in this Act as the "Center").

(b) The Secretary, through the Center, shall—

(1) compile, publish, and disseminate a summary annually of recently conducted research on elder abuse, neglect, and exploitation;

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of elder abuse, neglect, and exploitation;

(3) compile, publish, and disseminate training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of elder abuse, neglect, and exploitation;

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the special problems of elder abuse, neglect, and exploitation;

(5) conduct research into the causes of elder abuse, neglect, and exploitation, and into the prevention, identification, and treatment thereof; and

(6) make a complete study and investigation of the national incidence of elder abuse, neglect, and exploitation, including a determination of the extent to which incidents of elder abuse, neglect, and exploitation are increasing in number or severity.

The Secretary shall establish research priorities for making grants or contracts under paragraph (5) of this subsection and, not less than sixty days before establishing such priorities, shall publish in the Federal Register for public comment a statement of such proposed priorities.

(c) The Secretary may carry out functions under subsection (b) of this section either directly or by way of grant or contract. The Secretary shall promulgate regulations setting forth criteria for programs receiving funding under this subsection and shall review programs funded under this subsection to determine whether such programs comply with such criteria. The Secretary shall, within thirty days after any determination by the Secretary that a program fails to comply with such criteria, terminate funding for such program.

(d) The Secretary shall make available to the Center such staff and resources as are necessary for the Center to carry out effectively its functions under this Act.

DEFINITIONS

SEC. 3. For purposes of this Act—

(1) the term "abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or

cruel punishment with resulting physical harm or pain or mental anguish; or the willful deprivation by a caretaker of goods or services which are necessary to avoid physical harm, mental anguish, or mental illness;

(2) the term "elder" means any person who has attained the age of sixty years;

(3) the term "caretaker" means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, receipt of payment for care as a result of family relationship, or by order of a court of competent jurisdiction;

(4) the term "exploitation" means the illegal or improper act or process of a caretaker using the resources of an elder for monetary or personal benefit, profit, or gain;

(5) the term "neglect" means the failure to provide for oneself the goods or services which are necessary to avoid physical harm, mental anguish or mental illness or the failure of a caretaker to provide such goods or services; and

(6) the term "physical harm" means bodily pain, injury, impairment, or disease.

DEMONSTRATION PROGRAMS AND PROJECTS

SEC. 4. (a) The Secretary, through the Center is authorized to make grants to, and enter into contracts with, public agencies or nonprofit organizations (or combinations thereof) for demonstration programs and projects designed to prevent, identify, and treat elder abuse, neglect, and exploitation. Grants or contracts under this subsection may be—

(1) for the development and establishment of training programs for professional and paraprofessional personnel, in the fields of health, law, gerontology, social work, and other relevant fields, who are engaged in, or intend to work in, the field of prevention, identification, and treatment of elder abuse, neglect, and exploitation;

(2) for the establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the special problems of elder abuse, neglect, and exploitation cases, to provide a broad range of services related to elder abuse, neglect, and exploitation, including direct support and supervision of sheltered housing programs, as well as providing advice and consultation to individuals, agencies, and organizations which request such services; and

(3) for furnishing services of teams of professional and paraprofessional personnel who are trained in the special problems of elder abuse, neglect, and exploitation cases, on a consulting basis, to small communities where such services are not available.

(b)(1) The Secretary, through the Center, is authorized to make grants to the States for the purpose of assisting the States in developing, strengthening, and carrying out elder abuse, neglect, and exploitation prevention and treatment programs.

(2) In order for a State to qualify for assistance under this subsection, such State shall—

(A) have in effect a State elder abuse, neglect, and exploitation law which shall include provisions for immunity for persons reporting instances of elder abuse, neglect, and exploitation, from prosecution arising out of such reporting, under any State or local law;

(B) provide for the mandatory reporting of known and suspected instances of elder abuse, neglect, and exploitation;

(C) provide that upon receipt of a report of known or suspected instances of elder abuse, neglect, or exploitation an investigation shall be initiated promptly to substantiate the accuracy of the report, and, upon a finding of abuse, neglect, or exploitation, steps shall be taken to protect the health and welfare of the abused, neglected, or exploited elder;

(D) demonstrate that there are in effect throughout the State, in connection with the enforcement of elder abuse, neglect, and exploitation laws and with the reporting of suspected instances of elder abuse, neglect, and exploitation, such administrative procedures, such personnel trained in the special problems of elder abuse, neglect, and exploitation prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with elder abuse, neglect, and exploitation cases in the State;

(E) provide for methods to preserve the confidentiality of records in order to protect the rights of the elder;

(F) provide for the cooperation of law enforcement officials, courts of competent jurisdiction, and State agencies providing human services with respect to special problems of elder abuse, neglect, and exploitation;

(G) provide that the elder participate in decisions regarding his or her own welfare, and provide that the least restrictive alternatives are available to the elder who is abused, neglected, or exploited;

(H) agree to pay, with funds from non-Federal sources, 50 percent of the cost of the program for which assistance under this subsection is made available;

(I) provide that the aggregate of support for programs or projects, related to elder abuse, neglect, and exploitation, assisted by State funds shall not be reduced below the level provided during the twelve months preceding the date of the enactment of this Act, and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects; and

(J) provide a State clearinghouse for dissemination of information to the general public with respect to the problems of elder abuse, neglect, and exploitation, and the facilities and with respect to prevention and treatment methods available to combat instances of elder abuse, neglect, and exploitation.

(c) Assistance provided pursuant to this section shall not be available for construction of facilities; however, the Secretary is authorized to supply assistance for the lease or rental of facilities where adequate facilities are not otherwise available, and for repair or minor remodeling or alteration of existing facilities.

(d) The Secretary shall establish criteria designed to achieve equitable distribution of assistance under this section among the qualifying States, among geographic areas of the Nation, and among rural and urban areas. To the extent possible, citizens of each qualifying State shall receive assistance from at least one project under this section.

AUTHORIZATION

SEC. 5. There are hereby authorized to be appropriated such funds as may be necessary to carry out the purposes of this Act.

EFFECTIVE DATE

SEC. 6. This Act shall take effect on January 1, 1990.

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SUMMARY OF H.R. 220
THE ELDER ABUSE PREVENTION, IDENTIFICATION AND TREATMENT ACT OF 1989
Introduced by Congresswoman Mary Rose Oakar

NATIONAL CENTER ON ELDER ABUSE

H.R. 220 calls for the creation of a National Center on Elder Abuse. The Center will perform the following functions:

1. Compile, publish and disseminate a summary annually of recently conducted research on elder abuse, neglect, and exploitation;

2. Develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of elder abuse, neglect, and exploitation;

3. Compile, publish and disseminate training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of elder abuse, neglect, and exploitation;

4. Provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the special problems of elder abuse, neglect, and exploitation;

5. Conduct research into the causes of elder abuse, neglect, and exploitation, and into the prevention, identification, and treatment of elder abuse; and

6. Make a complete study and investigation of the national incidence of elder abuse, neglect, and exploitation, including a determination of the extent to which incidents of elder abuse, neglect, and exploitation are increasing in number or severity.

DEMONSTRATION PROGRAMS AND PROJECTS

The Secretary of Health and Human Services, through the Center is authorized to make grant to, and enter into contracts with, public agencies or nonprofit (or combinations thereof) for demonstration programs and projects designed to prevent, identify, and treat elder abuse, neglect, and exploitation. Grants may be used for:

1. The development and establishment of training programs for professional and paraprofessional personnel, in the fields of health, law, gerontology, social work, and other relevant fields, who are engaged in or, who intend to work in, the field of prevention, identification, and treatment of elder abuse;

2. The establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the special problems of elder abuse, neglect, and exploitation cases, to provide a broad range of services related to elder abuse, neglect, and exploitation, including direct support and supervision of sheltered housing programs, as well as providing advice and consultation to individuals, agencies, and organizations which request such services; and

3. Furnishing services of teams of professional and paraprofessional personnel who are trained in the special problems of elder abuse, neglect, and exploitation cases, on a consulting basis, to small communities where such services are not available.

The Secretary of Health and Human Services, through the Center, is authorized to make grants to the States for the purpose of assisting the States in developing, strengthening, and carrying out elder abuse, neglect, and exploitation programs.

Appropriations are authorized.

Chairman **ROYBAL.** Thank you, Ms. Oakar.

The Chair would like to ask unanimous consent to place in the record the prepared statements of Representatives Thomas J. Downey, Harold Ford, Ralph Regula, and Helen Delich Bentley. Without objection, those statements will appear in the record at this point.

[The prepared statements of Representatives Downey, Ford, Regula, and Bentley follow:]

STATEMENT OF HONORABLE THOMAS J. DOWNEY
"ELDER ABUSE: A DECADE OF SHAME AND INACTION"

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
HOUSE SELECT COMMITTEE ON AGING
MAY 1, 1990

Mr. Chairman, I commend you for convening this hearing on elder abuse. Your Subcommittee's continuing work on this issue over the past decade has focused public attention on a tragic and persistent problem and I hope that the survey which you are releasing this morning will help Congress by providing us with the impetus we need to move elder abuse legislation in the House.

As you know, the Subcommittee on Human Services held a hearing on elder abuse last June and I was struck by the fact that, after ten years, the Federal government still lacked a focal point for its elder abuse efforts. Moreover, the Administration was quite reluctant to take the lead in elder abuse prevention and treatment efforts.

Happily, states and local governments as well as private agencies have stepped in to fill the void and today we find ourselves with a great diversity of elder abuse programs. Throughout the country, social service providers and law enforcement officials have developed responses to the problem of elder abuse.

In March of this year, the New York City Coalition on Elder Abuse and the Institute of Retired Professionals of the New School for Social Research sponsored a conference on elder abuse. Approximately 500 people attended the day long conference which focused on national and local issues. Last year, the Suffolk County (NY) Executive's Task Force on Family Violence issued a study on elder abuse in this suburban county. The task force queried 140 health and community and social service agencies and received responses from 106 of them. The report was covered in the local press and the Suffolk County Executive testified at the Subcommittee on Human Services hearing last June. These two recent examples from the New York metropolitan area show quite clearly that people who work with elderly people on a daily basis are aware of the problem of elder abuse and are concerned and actively engaged in trying to find a solution.

At the Federal level, we have a great deal to learn from state, local and private agencies, and in particular we have to be careful to respect the diversity of approaches. Left to their own devices by the inaction of the Federal government, the states have grappled with this issue with varying degrees of success. Our task must be to support their efforts and, where states have failed to develop programs, to encourage them with funds and guidance.

Section 371 of the Older Americans Act, adopted as part of the Older Americans Act Amendments of 1987 (P.L. 100-175), provides us with a useful foundation for Federal efforts in elder abuse prevention. It is consistent with the general thrust of the Older Americans Act, which allows state and local agencies discretion in implementation of the act. The particular genius of the Older Americans Act has been that it has recognized and encouraged local diversity in dealing with human service programs for elderly people. I make this point this morning because I believe it is important to keep in mind when we consider the question of mandatory reporting requirements. Eight states, my own among them, do not now have mandatory reporting laws affecting adult protective services, including elder abuse. Yet they do have elder abuse programs in place. I feel strongly that in this sensitive area we ought to continue to let the states decide how to proceed.

Unfortunately, funds for this section have never been appropriated and so we do not have the opportunity to evaluate its effectiveness. At the very least, I hope that we can secure an appropriation for this program this year.

Mr. Chairman, I thank you for holding this hearing this morning and I look forward to the witnesses' testimony.

Statement by Congressman Harold Ford

Subcommittee on Health and Long-Term Care

May 1, 1989

Thank you Mr. Chairman for calling this hearing as a means of addressing the problems of elderly abuse. I am pleased to acknowledge our witnesses who include members from our elderly population and those who work closely with the victims of abuse.

It brings me great dismay to hear from reports that 5 percent of our Nation's senior citizens suffer from some from of elderly abuse. Moreover, this estimate of 1.5 million victims does not adequately indicate the level of abuse due to the timidity and hesitancy of victims to report the incidents. Sources indicate that only 1 out of every 8 cases of elder abuse is reported. It further disturbs me that the rate of elder abuse is increasing, with an increase of 500,000 cases annually since 1980.

Obviously from these facts, it is evident that this problem deserves our immediate attention. So far, Congress has not adequately confronted this growing problem. Efforts to enact legislation to address elderly abuse have continued since 1980, yet we still do not have a sufficient national policy which provides a means to prevent and treat elder abuse.

States have begun to address this problem. Presently 42 states and the District of Columbia have adopted mandatory reporting provisions as part of their adult protective service statutes. However, the federal government has not provided the funding to support these programs and provisions. Further, these statutes are limited in depth and need to be updated and supported by a comprehensive and consistent national program.

I am eager to hear the report from our Chairman and the years of research undertaken and await the testimony of our witnesses as they enlighten us of the specific abuses suffered by our senior citizens. Hopefully, these hearings will propel efforts to create a national policy to address the problem of elder abuse and alleviate those helpless victims of this problem.

OPENING STATEMENT OF THE HONORABLE RALPH REGULA, R - OHIO

RANKING MINORITY MEMBER
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
MAY 1, 1990

MR. CHAIRMAN:

YOU ARE TO BE COMMENDED FOR YOUR EFFORTS IN CONDUCTING A HEARING ON THE IMPORTANT ISSUE OF ELDER ABUSE.

IN 1978, THE HOUSE SELECT COMMITTEE ON AGING HEARD TESTIMONY REGARDING ABUSE OF OLDER AMERICANS. AN INVESTIGATION WAS CONDUCTED WITH A REPORT BEING ISSUED IN 1981. WHAT THE COMMITTEE FOUND WAS THAT

ELDER ABUSE EXISTED WITH A FREQUENCY AND RATE ONLY SLIGHTLY LESS THAN CHILD ABUSE. ONE OUT OF EVERY 25 OLDER AMERICANS, OR ROUGHLY 1 MILLION ELDERLY WERE FOUND TO BE ABUSED ANNUALLY.

LAST YEAR, THROUGH A SERIES OF QUESTIONNAIRES AND TELEPHONE INTERVIEWS OUR SUBCOMMITTEE CONDUCTED A FOLLOW-UP INVESTIGATION. SEVERAL CONCLUSIONS WHERE REACHED:

- ABOUT 5% OF THE NATION'S ELDERLY MAY BE VICTIMS OF ABUSE FROM MODERATE TO SEVERE, OR ABOUT 1 OUT OF EVERY 20 OLDER AMERICANS.

- ONLY 1 OUT OF 8 CASES OF ELDER ABUSE IS REPORTED. THIS REPRESENTS A

SIGNIFICANT INCREASE FROM THE SUBCOMMITTEE'S 1980 ESTIMATE OF 1 IN 5 CASES.

- PRIOR TO 1981, ONLY ABOUT 1 IN 6 CASES OF ELDER ABUSE WAS REPORTED. TODAY, ABOUT 1 IN 8 CASES COMES TO THE ATTENTION OF PROTECTIVE SERVICES.

IT IS CLEAR THAT THE PROBLEM HAS GROWN WORSE. TODAY, THE FOCUS OF OUR HEARING WILL BE UPON THE NEED FOR FURTHER FEDERAL ASSISTANCE TO THE STATES FOR THE DEVELOPMENT OF THEIR ELDER ABUSE STATUTES TO CORRECT THESE PROBLEMS. ALTHOUGH THE RECOMMENDATIONS OFFERED BY THE CHAIRMAN MAY BE VIEWED AS INAPPROPRIATE BY SOME MEMBERS, DUE TO THE COST IMPLICATIONS AND

QUESTIONS OF JURISDICTION OVER THE STATES, THE OVERALL ISSUE IS BIPARTISAN IN NATURE. I AM CONFIDENT WE CAN WORK TOGETHER TO HELP THOSE ELDERLY BEING ABUSED.

OUR CHAIRMAN IS CORRECT THAT ACTION MUST BE TAKEN. CONGRESS SHOULD AUTHORIZE STATE MEDICAID FRAUD CONTROL UNITS TO INVESTIGATE AND PROSECUTE ALL RESIDENT ABUSE AND NEGLECT COMPLAINTS. USE OF THE LEGAL SERVICES CORPORATION TO PROVIDE LEGAL ASSISTANCE TO ABUSED ELDERS IS ALSO A NECESSARY STEP. MANY OF THESE PROPOSALS ARE SIMILAR TO LEGISLATION I INTRODUCED IN THE 99TH CONGRESS. HOWEVER, OUR ACTIONS MUST BE MEASURED AND CALCULATED TO BEST UTILIZE EXISTING

RESOURCES SO THAT TAXPAYERS' DOLLARS ARE NOT NEEDLESSLY WASTED.

I LOOK FORWARD TO THE THOUGHTFUL COMMENTS OF OUR WITNESSES ON THIS IMPORTANT MATTER.

STATEMENT BY HELEN DEL[illegible] BENTLEY
BEFORE THE SELECT COMMITTEE ON AGING
ON TUESDAY, MAY 1, 1990

Mr. Chairman, I appreciate the opportunity to be here today in order to explore what amounts to a dirty little secret in our society --- one, I might add, that is no longer all that "little." The facts about this issue first came to light in an official capacity back in 1981 when this Committee introduced it's findings concerning the problem of elder abuse.

It is estimated that well over 1 million seniors suffer psychological and physical abuse -- and the number is expanding. The problem of elder abuse transcends each and every racial and economic line in contemporary society. However, one of the major hurdles that we need to overcome in terms of confronting elder abuse head-on, is the lack of information that exists regarding solutions available to those suffering abuse in the home.

On a more positive note, there have been some major steps taken in the fight against elder abuse as evidenced by the fact that an increasing number of states have protection statutes in place. Congressional attempts to deal with elder abuse in a more comprehensive manner have been well intentioned but not necessarily effective -- budget constraints being the prime factor.

Again Mr. Chairman, I thank you for shedding a bit more light on this issue -- I look forward to hearing the witnesses testimony.

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Chairman **Roybal**. The Chair now recognizes Mr. Jontz.

STATEMENT OF REPRESENTATIVE JIM JONTZ

Mr. **Jontz**. Thank you, Mr. Chairman, I'll be very brief.

I want to commend you for scheduling this hearing. As a State legislator, I was involved in writing our State's law and I became familiar firsthand with the problems we have, as the gentlewoman from Ohio has outlined, and you outlined in your opening statement. I think it is very timely that our subcommittee take up this matter.

I note that from the report on the table with regard to the ratio of report cases to unreported cases, and my own State of Indiana makes an estimate of the lowest ratio of any of the States. I think that's an indication that we recognize how far we have to go in terms of improving the means by which this problem is dealt with.

I pledge my support to you, Mr. Chairman, and the other members of this committee, to make every effort here in the Congress to supplement the efforts of the States to assist them in addressing this problem.

I thank you, Mr. Chairman, for the time this morning.

Chairman **Roybal**. Thank you very much.

The Chair would now like to recognize Ms. Schneider.

STATEMENT OF REPRESENTATIVE CLAUDINE SCHNEIDER

Ms. **Schneider**. Thank you, Mr. Chairman. I'm hot on the heels of my arrival here; I regret that I have not had the benefit of hearing what some of the experts had to say. I look forward to the additional testimony.

However, I will say that insofar as the question we're discussing here today, Elder Abuse: A Decade of Shame and Inaction, it's clearly time. I come from the great State of Rhode Island and I've been studying the crime statistics nationwide and as they relate not only to our region but also to our State.

It is rather horrifying to me that there seems to be an inexplicable increase in the number of crimes, not only against elderly but also against women. I think that this is a societal challenge, and I appreciate your leadership, Mr. Chairman, in calling for this hearing so that hopefully we can get a little better insight as to how we can best address this challenge.

Thank you.

Chairman **Roybal**. Thank you, Ms. Schneider.

The Chair recognizes the gentleman from New Mexico, Mr. Richardson.

STATEMENT OF REPRESENTATIVE BILL RICHARDSON

Mr. **Richardson**. Thank you, Chairman Roybal. Again, I wish to commend you for holding this hearing.

I think what we are witnessing today on elder abuse is outrageous. I think it's immoral that 550,000 to 2.5 million elders are the victims of physical and emotional abuse in this country. Not only that, but also neglect and denial of their fundamental civil rights.

What we have here is an increase of 100,000 cases a year since 1981. One out of 20 older Americans, or 1.5 million elderly Americans, may be victims of elder abuse. And what do we have to deal with this problem? Declining resources at the State and local level.

Additionally, only one in eight cases of elder abuse comes to the attention of the appropriate authorities. I think, Mr. Chairman, this is an outrageous situation that demands some kind of a solution. I think it involves not just what my colleague Ms. Oakar said, and passing a national health care bill—which I think is needed—but I think we need some stop-gap measures that deal with this. We're not dealing with this problem. It is shocking, that there has been a 50 percent increase in elderly abuse in this country since 1981.

Again, Mr. Chairman, I commend you for holding this hearing but I think our focus should be on what do we do about it.

[The prepared statement of Mr. Richardson follows:]

PREPARED STATEMENT OF REPRESENTATIVE BILL RICHARDSON

Mr. Chairman, I commend you for holding this hearing today on the issue of elderly abuse. This issue is a serious one that needs our attention and our action.

It has been over ten years since the Committee held its first hearing on elderly abuse, bringing to light the horrifying problem so many of our elderly population are facing. Yet, Mr. Chairman, as I'm sure you are aware, it is estimated that 550,000 to 2.5 million elders are the victims of physical and emotional abuse, neglect and denial of their fundamental civil rights. According to a 1987 report published by the American Medical Association, 1 in every 25 Americans age 65 or older - approximately 1.1 million - suffer from moderate to severe abuse. This represents an increase of 100,000 cases a year since 1981. The Subcommittee's report details numbers that are even higher - 1 out of every 20 older Americans or 1.5 million may be victims of elder abuse.

These are astonishing and outrageous numbers. Unfortunately, we are just beginning to realize how tragic this situation really is. States and local agencies simply do not have the resources to deal with all the cases they have and there are even more cases that no one is aware of. Mr. Chairman, you said so yourself, "only 1 in 8 cases of elder abuse comes to the attention of the appropriate authorities".

Mr. Chairman, I truly hope this hearing will help us better prepare ourselves to deal with this tragic situation both through financial resources and emotional ones. I look forward to hearing from our distinguished panel of experts.

Chairman **Roybal**. I thank the gentleman. Ladies and gentlemen, the next thing we are going to do is hear from the witnesses; we'll hear from all the witnesses, then we will go into a 5-minute period so that each member of the committee can ask questions of any one of the witnesses or all, if they desire.

The witness panel is made up of Mr. Jones, a gentleman who is 75 years old, and has been the victim of physical abuse; Mr. Harshbarger, who is the District Attorney from Middlesex County, Massachusetts, and who will give us the legal perspective on elder abuse; Ms. McLaughlin, who is the Program Director of Services to The Aged, comes from Houston, Texas.

Then we will hear from Sue Parkins, who is an M.D. She will tell us about the emergency programs and whatever she has to offer with regard to the medical profession.

Not on the panel, but one whom we've asked to be present, is Dr. Tatara, who is a Ph.D. and serves as Director of the National Aging Resource Center on Elder Abuse. They have prepared a report that has taken a long time to compile. We are going to ask him to make that presentation and to make whatever remarks he desires with regard to the report.

We will ask, then, that Mr. Jones start off the discussion, and he is now recognized.

Mr. Jones?

STATEMENT OF MR. JONES, VICTIM OF PHYSICAL ABUSE, CAMBRIDGE, MASSACHUSETTS, ACCOMPANIED BY SCOTT HARSHBARGER, DISTRICT ATTORNEY, CAMBRIDGE, MIDDLESEX COUNTY, MASSACHUSETTS

Mr. **Jones**. Good morning, Mr. Chairman and members of the subcommittee. I have chosen not to use my real name today because my story is a difficult one to tell in public.

Elder abuse is happening. I know. I lived through the experience of being a victim of elder abuse at the hands of a family member. I know what it is like to sleep behind a locked bedroom door in my own house.

My wife and I are victims of long-term abuse by our 43-year-old son. The abuse went on for many years. It is difficult for me to know exactly when it began—perhaps 20 years ago.

I do know that since 1986, we have had restraining orders from the courts against my son. At various times, my wife and I were choked, punched, slammed against walls, kneed in the back, slapped in the face, knocked to the floor, and verbally harassed. One time he even threw hot soup in my wife's face.

My son has a history of alcohol abuse. His attacks on us were usually when he was drunk but later happened when he was sober.

My son was charged with assault and battery for physically abusing my wife and me on Christmas Eve, 1988. Had a relative not gotten involved, I think he might have thrown me down the stairs. He was convicted, but we did not want him to go to prison. We asked the Assistant District Attorney not to recommend that he be put behind bars. I made the same appeal to the judge who heard my boy's case. After all, even though we lived in fear of him, he is still our son. The judge gave him a suspended sentence.

After leaving for a period of time, my son later returned to our house. It all began again. In February of this year, he demanded money from his mother to buy alcohol. He slapped her across the face. My wife did not want to say anything about it to me. But, the next day, he kept pushing the both of us around and verbally taunting us, finally forcing us into our locked bedroom.

I had to do something and went to the police. Fear for our own safety finally outweighed any parental instinct to protect our son from whatever going to the police might mean for him.

My son was convicted in March for his latest attack on us. He is now in prison in Massachusetts. It hurts me to know my son is incarcerated, but I realize that it means we are safe now. My wife is less accepting of the situation. Despite what he did to us, she cannot bear the thought of his being in prison. But now we are safe. We don't have to sleep behind a locked bedroom door anymore.

As I said in the beginning, I hope my story will help you to believe that these things are happening to older people. They are not easy to talk about. The victims must know that there is a place to turn. Many people probably don't do anything because they are scared or embarrassed. Please let them know that you care and will help.

Thank you.

[The prepared statement of Mr. Jones follows:]

STATEMENT OF "MR. JONES"
CAMBRIDGE, MASSACHUSETTS

Good morning, Mr. Chairman and members of the Subcommittee. I have chosen not to use my real name today because my story is a difficult one to tell in public. When originally asked to come to Washington to tell my story, I had one thought -- no one will believe it.

I am here today with District Attorney Harshbarger to ask you to please believe it.

Elder abuse is happening. I know. I lived through the experience of being a victim of elder abuse at the hands of a family member. I know what it is like to sleep behind a locked bedroom door in my own house.

First, I would like to tell you a little about myself. I am 75 years old and married. My wife is 80 years old and in poor health. A few years ago, I had a double hip replacement operation. Before I retired, I worked for a food manufacturer. We live in a two-family house, which I have owned for nearly 40 years, in a middle class neighborhood.

By all outward signs, we are a normal retired couple. But, I am sad to say that our lives have not been quite that simple. Both of us are the victims of long-term abuse by our 43-year-old son. The abuse went on for so many years, it is difficult for me to say exactly when it began -- perhaps 20 years ago.

I do know that since 1986, we have had restraining orders from the courts against my son. At various times my wife and I were choked, punched, slammed against walls, kneed in the back, slapped in the face, knocked to the floor and verbally harassed. One time he even threw hot soup in my wife's face.

My son has a history of alcohol abuse. His attacks on us were usually when he was drunk but later happened when he was sober, too. He has never been able to hold a job for very long, except for when he worked at the post office. He lost that job because of his drinking. When he was not living in our house, he really did not have a home.

My son was charged with assault and battery for physically abusing my wife and me on Christmas Eve, 1988. Had another relative not intervened, I think he might have thrown me down the stairs. He was convicted, but we did not want him to go to prison. We asked the assistant district attorney not to recommend that he be put behind bars. I made the same appeal to the judge who heard my boy's case. After all, even though we lived in fear of him, he is our son. The judge gave him a suspended prison sentence.

After leaving for a period of time, my son later returned to our house. It all began again. In February of this year, he demanded money from his mother to buy alcohol. He slapped her across the face. My wife did not want to say anything about it to me. But, the next day, he kept pushing both of us around and verbally taunting us, finally forcing us into our bedroom. I had to do something and later went to the police. Fear for our own safety finally outweighed any parental instinct to protect our son from whatever going to the police might mean for him.

My son was convicted in March for his latest attack on us. He is now in prison in Massachusetts. It hurts me to know my son is incarcerated, but I realize that it means we are safe now. My wife is less accepting of the situation. Despite what he did to us, she cannot bear the thought of our boy being in prison.

I would like to say that I have seen a big change in the way we have been treated by the system over the years. About 20 years ago, I applied for a criminal complaint against my son for physically abusing us. A clerk of courts quickly dismissed my complaint and suggested I go see a psychiatrist. Fortunately, it is different now. When things got real bad and we went to the police, people began to help us. The assistant district attorney listened to me. The victim witness advocate kept me informed about our case and stayed with me when I had to testify. That support is important when you have to say these terrible things that your son has done to you.

I cannot feel any hate towards my son and I am sorry that he is in prison. And my wife is very sad about where he is. But, now we are safe. We don't have to sleep behind the locked bedroom door anymore.

As I said in the beginning, I hope my story will help you to believe that these things are happending to older people. These incidents are not easy to talk about, but victims must know that there is a place to turn. Many people probably don't do anything because they are scared or embarrassed. Please let them know that you care and will help. Thank you.

Chairman ROYBAL. Mr. Harshbarger, the Chair will now recognize you to proceed in any manner which you may desire.

STATEMENT OF SCOTT HARSHBARGER

Mr. HARSHBARGER. Thank you very much, Mr. Chairman.

My name is Scott Harshbarger, District Attorney of Middlesex County, Massachusetts. Tragically, Mr. Jones' case occurred in our county, and we had the responsibility to prosecute his son.

I appeared here 5 years ago and met many members of the committee at that time, and I commend all of you for continuing to focus on the tragic reality of elder abuse. Every experience that I've had in the 5 years since then confirms my prediction made at that time: the problem of elder abuse and crimes against the elderly may very well make the problem of child abuse pale by comparison.

We are seeing just the tip of the iceberg. It is a national tragedy. I commend you for once again focusing public awareness on these cases.

I would also, and I'm sure I know I speak for all of you, like to thank Mr. Jones for being willing to come forward to discuss this tragic problem and his unfortunate victimization. The victim witness advocates in our office, who are key to this entire criminal justice process worked with Mr. and Mrs. Jones and, frankly, no one could have expressed better what a painful experience it has been.

Mr. Chairman, I'd like to make a few specific points. I have submitted written testimony that I would like to offer at the conclusion of my remarks; our Middlesex County District Attorney's Action Plan for Crimes Against the Elderly, which is the program that I described 5 years ago and have updated since; our report on Crimes Against the Elderly, which details preliminary findings from our study of cases involving elderly victims in Middlesex County; as well as the State Office of Elder Affairs' Protective Services Report that was recently issued.

All of these materials will, unfortunately, confirm everything that we talked about 5 years ago, and everything that's in your staff report.

First, it is my view that the problem of elder abuse is symbolic of our general societal neglect and mistreatment of the elderly in this country.

In my view, in dealing with elder abuse, we must have law enforcement integrally involved. From my experience, prosecution is a crucial and necessary response to the problem of elder abuse. We, as prosecutors and police in this country have become involved in these family matters primarily because of the failure of other institutions. And the reality is, for the past several years we have focused and spent much of our time dealing with child abuse, family violence, domestic violence and now the tragic problem of elder abuse.

We have criminalized these problems because no one else is effectively dealing with them. Prosecution is certainly not an effective response alone and is not the entire solution, but it plays a crucial role, I believe, in addressing a very basic truth. The fact of the matter is that today, in America, in Middlesex County and in Massachusetts, you are more likely to be the victim of a violent crime at the hands of a family member than you are by a stranger. These are crimes that are committed mostly by men against women.

In the case of children, we've already seen the studies. In the case of domestic violence, more than 1 out of every 10 murders in my county are committed by men, either husband or boyfriend, who are estranged from a wife or girlfriend.

In the cases of elder abuse, Mr. Jones' case, while tragic, is absolutely classic. The vast majority of offenders from our study are males. The majority of the victims are female. Most of the perpetrators are related to the victims. And, tragically, the majority of the victims are 70 years of age or older. It is a real and very vicious cycle of family violence and we are now discovering that parents and older Americans are also a part of it.

We must pierce this family veil and address the realities of elder abuse just as we have addressed the realities of child abuse and domestic violence.

The United States Congress was key, 16 years ago, in addressing and recognizing the problem of child abuse through a bill like the elder abuse bill you are now considering. It was that child abuse bill in 1974 that led to increased reporting and the discovery of the level of tragedy caused by child abuse.

Let me just tell you about one other elder abuse case in addition to Mr. Jones; to give you an idea of the type of elderly victimization taking place. In December of 1987—a 20-year-old man from Middlesex County was convicted of first-degree murder for killing his grandmother. The defendant had repeatedly beaten her over the head with a decanter and stabbed her with a knitting needle.

Following the murder, the grandson stole his dead grandmother's car and jewelry. He is now serving a life sentence in State prison. I would emphasize it clearly that the defendant was involved with drug and alcohol abuse.

Mr. Jones has described his case to you in eloquent detail. These are crimes. They must be prosecuted as crimes. As I previously stated, prosecution while important, is not the only solution.

Our Action Plan that I described to you is one that I am especially proud of. And I'm pleased to be on this panel with experts from around the country, professionals with whom I have had the opportunity to discuss elder abuse in a number of forums. It is a focus for my office which emphasizes coordinated multidisciplinary approaches, priority prosecution of cases violent crime, street crime, cases involving elderly victims and white collar crime, which is clearly the most common crime that affects older Americans. More importantly, the plan involves the training of Elder Protective Services' workers, police officers who must play a major role in the multidisciplinary approach and, finally, crime awareness and prevention.

Just one other aspect of crimes against older Americans I wanted to mention was financial exploitation of the elderly, which I know is part of your focus. The reality is that the elderly are systematically targeted for financial scams and schemes. And it appears to me to be the major type of crime, aside from abuse and neglect, of which the elderly are commonly the victims.

However, like elder abuse and neglect, we have found that few of these financial abuse cases are reported. They are not reported by the victims often because of guilt, shame, embarrassment, or isolation. They're not reported until all of the investments and all the money is gone; then maybe a neighbor or somebody else becomes involved. That is the problem we face—often it is too late to help.

But ultimately, even if we have prosecution, multidisciplinary approaches and effective reporting, the best solution is clearly prevention, and prevention is what we're all seeking here. Prevention cannot begin until we have multidisciplinary cooperation. With that multidisciplinary cooperation involving protective service workers, police and community agencies, the protocols and guidelines, a mandatory reporting statute, our reports of elder abuse and neglect have gone up 350 percent. This is a direct result of the training and the focused relationship that we have established.

But the problem is underreporting. And the question that all of us have come to recognize, but that the public still may doubt, is: does the number of cases that we see reflect all the cases that exist, or are they just the tip of the iceberg?

In my view, we have only begun to see the tip of the iceberg.

Some of the obstacles to reporting—and I think these are also the obstacles to prosecuting these cases that district attorneys face regularly—are that the perpetrator, often a loved one, is the victim's only means of support and the only connection with the outside world; the victim may fear retribution from the abusive relative or is embarrassed to reveal that a family member is abusive.

But a second reason for underreporting is the failure of professionals to recognize and fulfill their responsibility to report suspected cases of abuse. This issue must be addressed. It is crucial that the officials who are part of the mandated reporting system fulfill their responsibilities as they have in child abuse cases.

That's why H.R. 220, the Prevention, Identification and Treatment of Elder Abuse Act of 1989, in setting a framework, is crucial. I hope it will pass as one of the major steps necessary for us to begin to address the tragedy of elder abuse as a Nation.

But we cannot solve this problem unless we also address the root causes. I agree, as a prosecutor, with the statement of Congresswoman Oakar. If we do not also focus on the underlying causes—affordable housing, lack of effective health care, funding for caregiving agencies, the desperate need to provide financial and legal support and advice and guidance to older Americans—we will absolutely fail.

The best form of public protection is prevention. And it is more cost effective to spend money upfront on health care, affordable housing and legal services, thus preventing these situations from occurring, rather than waiting until the tragedies that we see at the end of the line in the criminal justice system.

I commend you for your leadership on this important issue. As a law enforcement official, I would be glad to assist you in any way, and I think I speak for the law enforcement community generally in urging you to call upon us in any way that you can.

I commend you for once again requiring this country to keep this matter on the public conscience and public agenda. It is the only way we will effectively address it. I hope that together we can ensure that 1990 will begin the decade we prevent elder abuse and not the decade that we accept it.

Thank you very much, and I offer these documents for the record.

Chairman **Roybal**. Thank you, Mr. District Attorney. The documents you have submitted will appear in the hearing record.

Mr. **Harshbarger**. Thank you very much.

[The prepared statement of Mr. Harshbarger follows: see Appendix II, p. 119 for additional material submitted by Mr. Harshbarger.]

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Prepared testimony
on Elder Abuse
before
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Introduction

Mr Chairman and members of the Subcommittee, I am honored and pleased to be invited back to testify before you today on the escalating national tragedy of elder abuse. I commend you and the Committee for once again focusing attention on this serious and complex problem, hopefully raising public awareness about its depth and scope, and emphasizing the reality that this victimization of older Americans will continue unabated if we do not all act together now.

Five years ago, I testified before this Subcommittee, chaired by the late Congressman Claude Pepper, and said that I feared we would soon learn that the tragedy of child abuse would pale in comparison to the systematic familial abuse of older Americans. Unfortunately, I believe that my prediction was accurate. In spite of some positive and heroic efforts being made by many individuals and groups, both public and private, our failure to focus on elder abuse is symbolic of our general societal neglect of the elderly in America and our unwillingness to face realistically a range of major issues affecting them.

Today, as a local prosecutor with experience in attempting to develop an effective, multi-pronged response to the problem, I offer my perspective on where we have come since that Congressional hearing five years ago, what we are doing today and what steps we need to take to protect older Americans in the future.

The Role of Law Enforcement in Combating Elder Abuse

I believe law enforcement must be integrally involved in developing effective responses to the problem of elder abuse. The need for a prosecutorial response to elder victimization is clear and demonstrable. The reality is that in this past decade, the criminal justice system -- prosecutors, police and judges -- became primary vehicles for responding to the societal problems that the traditional "family matters" of child abuse, domestic violence and elder abuse represent. Largely due to the failure of other institutions in our society to cope with these longstanding problems, they have been "criminalized" by legislative mandate and are now within the purview of our criminal laws and law enforcement agencies.

As District Attorney of Middlesex County, Massachusetts since 1983, I have given priority to family violence, including elder abuse. Our modern day American society is faced with the cruel truth that any one of us is more likely to be assaulted by a member of our own family, or someone we know, in our own home, than by a stranger in the street.

Unfortunately, older Americans have not been spared as victims of the vicious cycle of family violence. In fact, because of their real or perceived vulnerability, they suffer most dramatically from the effects of crime.

Today, more than 30 million Americans are over the age of 65. By the year 2000 -- just 10 years from now -- that number will grow by another 5 million. In light of these statistical realities, our challenge -- our obligation -- must be to ensure that a longer life does not mean a loss in the quality of life for our elderly.

Piercing the Family Veil: The Realities of Elder Abuse

Elder abuse is one of those crimes, like child abuse and domestic violence, which has been shrouded in secrecy, seriously underreported, and historically dealt with as a "family" matter. But, make no mistake about it -- these "family" matters are crimes and they do occur.

My office recently concluded a study of disposed cases involving elderly victims in Middlesex County which revealed some troubling findings:

- 55% of the offenders were related to the victim;
- nearly two-thirds of the crimes involved physical abuse;
- 65% of the crimes were committed against females;
- 82% of the offenders were males; and
- more than half of the victims were over 70 years of age.

These crimes reflect a massive social problem, they shock us all and we hope there are solutions. But, they are happening and they cut across social, economic and geographic lines.

Two cases that my office has prosecuted in recent years may serve to illustrate the always tragic and sometimes gruesome nature of elder abuse.

First, in December, 1987, a 20 year-old man from Middlesex County was convicted of first degree murder for killing his grandmother. The defendant beat her repeatedly over the head with a decanter and stabbed her with a knitting needle. Following the murder, the grandson stole his dead grandmother's car and jewelry. He is now serving a life sentence in state prison.

Second, Mr. Jones, who joins me today, and his 80 year-old wife were the victims of long-term physical and mental abuse by their 43 year-old son, in their own home, for at least the last decade. His son was convicted of assaulting and battering both of them in March of this year and is now in prison.

Elder Abuse is a Crime

The stories are shocking and the elderly victims suffer more than other victims because of the inherent vulnerability that comes with aging, often silently; the pain doubled because the abuser is usually a relative. As the chief law enforcement officer of my county, I start with this premise: any individual who steals from, abuses or assaults an older American has committed a serious crime that must be viewed as such, regardless of the relationship between the offender and the victim. The offender must be identified, prosecuted and sanctioned.

I do not believe that the prosecution of these serious and complex cases is the only solution, but it does treat these acts of abuse and neglect for what they are -- crimes -- and forces professional and public awareness, response and accountability.

More positively, prosecution aids in therapy; the "leverage" is crucial to get offenders to enter into treatment and acknowledge wrongdoing. Prosecution also validates the victim and removes the stigma of inferiority, helplessness, and sense of guilt by demonstrating that the victim is not at fault.

Our Crimes Against the Elderly Action Plan

I cite these examples to support my belief that a major law enforcement response to crimes against the elderly is essential; they, and other similar cases, served as the impetus for our Action Plan for Crimes Against the Elderly: from "traditional" violent and street crime involving elderly victims, to consumer fraud and financial exploitation of elders, to serious elder abuse and neglect.

Since I testified in 1985, my office has updated, expanded and institutionalized our Action Plan. It is now the product of more than seven years of experience in prosecuting and investigating crimes against senior citizens, in having assistant district attorneys and victim witness advocates working directly with elderly citizens, and in reaching out to work with police, elder affairs agencies and senior citizen organizations. The Action Plan has several distinct parts:

- Coordinated multidisciplinary response to cases of elderly abuse;
- Priority prosecution and special handling of street and violent crime cases involving elder victims;
- White collar prosecution of economic crime and financial exploitation of elderly citizens;
- Training of elder protective service workers, police, medical and other relevant professional disciplines, and education of the public and professionals about elder abuse; and
- Crime awareness and prevention programs designed to prevent elder victimization from occurring.

Our Action Plan is an effort to establish an aggressive, efficient and effective approach aimed at protecting the rights of the elderly and preventing crimes against them -- on all fronts, in all cases where the elderly are victims of crime, whether by strangers, by people they know or by those in a familial or custodial relationship to them. And, when crimes against older Americans are reported, our goal is to ensure, by comprehensive, multidisciplinary work, that the elderly are not victimized a second time by the criminal justice system.

Financial Abuse of the Elderly: Targeting the Vulnerable

The victimization of the elderly is not confined to physical abuse. Our focus on family-inflicted physical abuse actually grew out of our initial concentration on a number of cases of financial exploitation of the elderly. We learned that older Americans were being victimized far more often by "white collar" crimes than by street crime, for several reasons: they often live alone, and, particularly in suburban communities; they are an easily identifiable, vulnerable target; they are often isolated and looking for, or needing, companionship; and they may have deteriorated physically and/or mentally and are slower to react. Because of this vulnerability, the elderly are frequently specifically chosen and targeted as victims of financial, insurance and home improvement scams and larceny by professionals in positions of trust and fiduciary responsibility.

We found that few of these crimes are reported by the victims (often because of the victim's own sense of guilt, fault and embarrassment at the sense of loss of control over their lives which the "crime" reinforced) and usually not until they were discovered by others, often after the victims' assets were gone.

The Best Protection of Older Americans: Prevention

Through increased public awareness, better training of the professionals who deal with the elderly, and enhanced awareness among elders themselves of the resources and assistance criminal justice agencies can provide, we will encourage the reporting of crimes, and in turn, we will be able to more effectively respond to crimes that are reported. But, prevention is surely the best protection for older Americans. Our goal must be to establish an aggressive, efficient, and effective approach aimed at protecting the rights of the elderly and preventing crimes against them, including elder abuse.

The Need for Multidisciplinary Cooperation

Prevention will not occur, and remedies cannot be developed, unless instances of elder abuse are reported. And for this reporting to happen in a routine and systematic manner, we must open the doors to interdisciplinary cooperation. To that end, my office's Family and Community Crimes Bureau has undertaken to replicate our experience with child abuse and domestic violence cases by initiating a comprehensive series of training and education seminars on our state's mandatory abuse reporting law with law enforcement officers and state Department of Elder Affairs protective service workers throughout Middlesex County. Specific protocols and guidelines for reporting and case reviews have been promulgated which provide the basic material for these training sessions.

As a direct result of the training and focused relationship with the other professional disciplines, elder abuse reports to the Middlesex County District Attorney's office increased by 350 percent between 1987 and 1989. The law enforcement and social services communities must develop working relationships and similar multidisciplinary training efforts. They are also crucial for mutual education and understanding of our respective roles and approaches in these cases.

The Underreporting Phenomenon

In this context, I think it is crucial to address the issue of why incidents of elder abuse, neglect and exploitation are so underreported and thus not prevented. Does the small percentage of cases that are reported reflect the actual rate of occurrence, or are these cases just the "tip of the iceberg," with many more just not being reported? I believe, based on our experience, that it is the latter.

In my view, there are two major obstacles to better reporting of elder abuse:

- Many elders do not report because the perpetrator, often a loved one, is their only means of support and their only connection with the outside world; they may fear retribution from the abusive relative; or they are embarrassed to reveal that a relative is abusing them; and
- The failure of professionals to recognize and fulfill their obligation to report suspected cases of elder abuse, and this is still true in Massachusetts even though reporting is mandated by statute.

Further resources must be devoted to education and training to allow elder protective service workers and law enforcement to intervene in a multidisciplinary manner and work towards our mutual goal of, if not preventing abuse, at least remedying an intolerable situation as quickly, effectively and sensitively as possible for the elderly victim.

Support for H.R. 220: The Prevention, Identification and Treatment of Elder Abuse Act of 1989

As a local prosecutor, the legislation proposed by Congresswoman Oakar represents an important practical step for the federal government to take and a major recognition that elder abuse is a genuine problem of national proportions.

Financial assistance from federal legislation would allow state and local government to devote resources to the areas of multidisciplinary prevention, identification, treatment and training on a larger scale than is presently possible in light of current fiscal restraints. With the help of the federal government, through passage of this legislation, I believe we would see a dramatic increase in reporting, thus remedying an untold amount of human tragedy and ultimately reaching our primary goal: preventing elder abuse from occurring.

I urge passage of this legislation. It will make crystal clear that the problem is real, the time to act is now and that the federal government is also prepared to recognize its obligation to older Americans.

Addressing the Root Causes

Ultimately, practical solutions must be developed -- over the next decade -- to address the root causes of victimization of older Americans:

- The need for dramatic expansion of financial advise and support programs;
- The restoration of elderly legal services which suffered severe cuts during the 1980's;
- Involvement of community leaders and agencies in responding to the isolation of the elderly;
- A major focus on adequate, affordable long-term health care and respite and support services;
- Earlier social service support intervention methods; and
- Adequate funding and professional staffing of the care-giving agencies.

We must be willing to pay for these solution and services. They must be "marketed" as our best form of public protection and be provided within this framework by all of us at the federal, state and local levels of government.

Conclusion: Working Together for the Sake of Older Americans

In October, 1988, I had the honor of delivering the keynote address at the Fifth Annual Adult Protective Services Conference in San Antonio, Texas. I said that all of us from our varied disciplines who deal with elder issues must act together to change public attitudes and understanding about the realities and needs of older Americans. I asked the participants of that conference to pledge to return in the year 2000 being honestly able to say individually and collectively we did all we could to restore the confidence of the elderly in our system and, more importantly, empower them to once again take control of their lives and erase the fear of crime, neglect and exploitation that increasingly immobilizes them and destroys their access to the American dream: the right to freedom and liberty and the opportunity to live a life of power and dignity. I hope, too, that those of us here today in this forum will make that same bold and proud pledge -- and fulfill it.

Mr. Chairman, and members of the subcommittee I commend you for your leadership on this important issue and thank you for this opportunity to offer my thoughts. As a law enforcement official attempting to cope with the everyday realities of elder abuse, I am prepared to do all I can to assist you. I hope our experiences and our efforts will be useful as you continue to raise the public consciousness about this national tragedy and seek the genuine solutions we are obliged to find and implement.

Together, let us ensure that 1990 begins the decade we prevent elder abuse and not the decade we accept it.

Thank you.

Chairman ROYBAL. I would like to acknowledge the presence of a very distinguished guest. There is no doubt that the problem of elder abuse is not only in the United States but throughout the world. Present this morning is a gentleman from the Soviet Union, who is the leader of the Soviet Delegation on the Elderly, and that is Mr. Alexander Golyakov. Thank you, Mr. Golyakov, for your presence.

Mr. Golyakov is here in the United States looking over some of our problems. He is attending this hearing with interpreters from the State Department; therefore, he will be given the benefit of your recommendations in his own language by State Department officials.

The Chair will now recognize Ms. Jan McLaughlin

STATEMENT OF JAN McLAUGHLIN, PROGRAM DIRECTOR, SERVICES TO AGED AND DISABLED, TEXAS DEPARTMENT OF HUMAN SERVICES, HOUSTON, TEXAS, ON BEHALF OF MR. HERNANDEZ, SON OF ELDER ABUSE VICTIM, HOUSTON, TEXAS

Ms. MCLAUGHLIN. Good morning. My name is Jan McLaughlin and I am a Program Director with Adult Protective Services in Houston, Texas. I'd like to thank you for the opportunity to speak with you all today about a problem of great concern for all of us.

I work for the Texas Department of Human Services and we are charged with the task of investigating reports of elder abuse and neglect as well as exploitation. Some of these reports that we receive are unfounded, but almost 82 percent of the reports that we receive are valid.

Last year in Texas, we received over 22,000 reports of abuse or neglect of the elderly and found over 18,000 of those to be valid reports. Our findings reveal that these are not isolated instances, but chronic situations of battering, unnecessary confinement, withholding of food, water, medication; overmedication, as well as sexual abuse and financial exploitation.

I would like to share with you some examples of how our elderly are living and dying in Texas. This is how some of our citizens, through absolutely no fault of their own, are spending their golden years. These cases are not atypical of what we find when we investigate reports and, of course, in order to protect the confidentiality of our clients I will not use their names.

Ms. A was only 68 years old when we learned about her situation. She had suffered a stroke and as a result of that was paralyzed on her left side and confined to a wheelchair. She was also suffering from hypertension and heart disease. She was completely incontinent. She lived with her daughter in a two-bedroom house.

The report that we initially received contained several allegations of neglect, among them that the client's daughter, who was an alcoholic, was physically and verbally abusive; that the client was found lying on the floor, nude and wet while her daughter, her caretaker, was drinking in the other room. The daughter had reportedly said that she "didn't care if her mother lived or died." The neighbors had told of the daughter whipping the client and also allowed her 8-year-old daughter to whip her grandmother. When we visited Ms. A she denied any mistreatment by her family, which is not all uncommon in cases of elder abuse.

Upon our investigation, several neighbors and other interested individuals told of horrifying instances of abuse. One night a neighbor found her lying on the ground, naked, with ants crawling all over her body. Because she was paralyzed, she was unable to get herself up and back into her wheelchair and into her house.

Providers in their home had found the client lying on the floor, nude, covered with urine and feces. The client told the provider that she had been there for 3 days. The daughter had refused to allow anyone to clean her mother up or even cover up.

When we visited the client, our worker found her tied to a wheelchair with electrical cords and sheets. She was crying and begging to be untied. At that time, she was admitted to an intensive care unit at a local hospital, malnourished, and covered with insect bites and sores.

The client refused all offers of alternative living arrangements and she was deemed competent by her own physician, and at her insistence she was released to her home. She died from continued extreme neglect, 1 month later, while her daughter and her friends drank in the next room.

Then there is the case of Ms. R who was 95 years old. Our staff received a call one day from a paramedic who had been called to her home. Behind me you will see pictures of Ms. R when she was admitted to the hospital by the paramedics.

When they tried to lift her, her skin literally came off. She had been lying in urine for such a long time that her skin had decomposed. And you can see the picture on my right is her back, and there are several open sores and lesions as well as pictures on my left of her legs where her skin, when touched, came off to the touch.

There were several people in this lady's home, but the primary caregiver and the alleged perpetrator was her daughter. While we had initially visited her in the hospital, we did visit her home. The home was cluttered, in disrepair; there was a strong odor of urine throughout the house. The client's room was in the back of the house, barely large enough to hold a bed.

The client died 2 days after she was admitted to the hospital. And you could tell by just looking at these pictures that she must have been in horrible, horrible pain.

Our investigation was validated for caretaker neglect. Information concerning this case was shared with the police department and the district attorney's office, but to the best of our knowledge, no charges were ever pursued.

The last case I want to speak with you about this morning is Mrs. Hernandez, who is an Alzheimer's victim, and whose son, Mr. Hernandez, is with me today. I would like to read his brief statement to you regarding his mother's financial abuse and neglect at the hands of his elder brother.

STATEMENT OF MR. HERNANDEZ, AS READ BY JAN McLAUGHLIN

Ms. McLAUGHLIN. [Reading] My name is Mr. Hernandez and I live in Houston, Texas. It's not easy for me to talk about this, but elder abuse has been going on in my family for years. I'm going to tell you about it anyway because I think it's important to do something to stop this problem.

Five years ago my father died, leaving my mother, then 78, to live on her own. She had Alzheimer's disease and my brothers and sisters and I knew that we needed to help her. We hired people to care for her in her home.

Things were going fine until my older brother came into the picture and he moved in with my mother.

My brother has always been a problem—he drank a lot; never held a job and never took care of his many children; he has at least 10 by three different wives. When he drank too much, which was often, he would get violent and abusive.

Early last year, without our knowing it, my brother went to the railroad retirement office and had himself named the recipient of my father's retirement checks. That money was supposed to go toward my mother's care but my brother would simply convert it to his own use, spending most of it on alcohol.

He began neglecting her horribly. He made her life a nightmare. Bills weren't paid. At one point, the gas, phone and water were shut off. We learned that my brother wasn't buying food for my mother, so she barely ate. Sometimes he'd leave her locked in the house unattended.

Another time, when he hadn't locked the door, we found her wandering outside our home. We were terrified that if it happened again, she'd be hit by a car. My brothers and sisters and I tried to speak with him about how he was neglecting my mother. He just wouldn't listen or accept help. He even changed the locks on the doors so that we wouldn't be able to check up on mom. He was holding my mother hostage in her own home.

The list of abuses goes on and on. He didn't bathe my mother. He wouldn't wash her clothes. Without heat and food she was vulnerable to illness and malnutrition. All my brother cared about was getting her money, not her.

Adult Protective Services in Houston eventually received an anonymous report. When they came to investigate, they found my mother malnourished, wearing only dirty underpants, with no other clothes in sight. The social workers asked my brother if he would leave the home that afternoon. "You're running me out of my house," he screamed. And the social worker replied, "No, it's not your house, it's your mother's, and you are hurting her."

My brother has finally left—we don't even know where he is—and I'm now in charge of my mother's care. This whole thing has been horrible and I'm sure cases like it are going on all over the country. Please do something to stop it.

Thank you.

Ms. **McLaughlin**. [Continuing with her statement] Last year in Texas we received over 22,000 reports of abuse of the elderly and the disabled. And it is estimated that only 10 percent of our cases are brought to our attention, even though there's a mandatory reporting law in our State. The greatest majority of our reports are initiated by social service professionals from hospitals, home health agencies and other social service agencies. Neighbors and relatives also comprise a significant percentage of those who report.

There are numerous theories about why elder abuse happens: drugs, alcohol, stressed caregivers, and the financial burdens encumbered when caring for frail elderly individuals. But the fact remains that while protective service cases have doubled in Texas, they only represent a small percentage of the population at risk. In 1985, we completed over 10,000 investigations, served over 7,000 clients, and determined that the population at risk was over 106,000 elderly people. In 1989, we completed over 22,000 investigations, served over 18,000 clients, and have determined over 113,000 clients to be at risk.

In our State we provide protective services to both the elderly and the disabled but our statistics indicate that of all the individuals served, 70 percent are elderly.

In serving those victims who are reported, our greatest problem is the shortage of resources such as emergency shelters, medical and psychological services, and appropriate residential care. We have also identified a great need in the area of identifying individuals to serve as guardians for our clients and in securing medical treatment for incapacitated individuals.

We believe that education and outreach are the keys to increasing the number of existing situations that are brought to our attention. However, due to lack of funding, the size of our current caseloads and the shortage of resources, we are unable to become involved in an adequate public awareness campaign. This campaign should include informing and educating our communities, medical as well as legal professionals, and victims and their families, not only about elder abuse but about the services that are available. Without additional funding, we do not have the resources to respond to the increased numbers of cases that we know would be a result of such a campaign.

Texas is only 1 State in 50. There is no reason to believe that elder abuse is any more or less of a problem in Texas than in any other State. Elder abuse is a societal problem, and each of us must claim these problems as our own or we will not begin to work on them. So I would ask that each of you, as Members of Congress, to make a commitment to accept the problem of elder abuse as your own and then work to begin to solve it.

Thank you.

Chairman ROYBAL. Thank you, Ms. McLaughlin. The Chair now recognizes Dr. Parkins.

STATEMENT OF SUE M. PARKINS, M.D., F.A.C.E.P., MEDICAL DIRECTOR, ADULT PROTECTION TEAM, ST. VINCENT MEDICAL CENTER, TOLEDO, OHIO

Dr. PARKINS. My name is Sue Parkins. I am from Toledo, Ohio, St. Vincent Medical Center. We have in St. V's an Adult Protective Team, which apparently was one of the first in the Nation. We started in about 1983 after our social worker was presented with a horribly convoluted and complicated case. She went to our hospital administration and said, you know, this is impossible for one person to handle alone; we ought to deal with this like we do with child abuse—which is an eminently reasonable statement. That's the way we do it in our hospital; we staff individuals as they come into our facility. They present either through the emergency department or to the floor and are usually identified by an R.N. who will fill out an internal reporting form—it's our document.

The social worker or usually the Adult Protective Team worker will be contacted and will review the case and make a referral to the Adult Protective Services unit in Ohio if it's a home care situation, or the Nursing Home Ombudsman or the Attorney General's office if it's someone coming from a care facility.

We will track the case internally. And an amazing number of these cases don't have enough evidence on the initial visit for people to believe that this kind of thing is happening. And one of my integral roles is trying to convince doctors that people are phenomenally inhuman to their relatives.

I have a number of slides to demonstrate some of the abuse that we've seen in our situation. We're one of nine hospitals in a community that's about a million, and we have about 30 cases a year that are of enough severity that we feel very confident that they represent abuse, neglect or exploitation.

One of the frustrations that we have in dealing with the elderly—they are a frail population. If you've ever raised children you know how frustrating and debilitating it can be personally to have to get up several times during the night with a baby.

We have people in the private sector who are caring for confused elderly family members who are also getting up many times during the night; and they, frankly, outstrip their emotional resources.

We have people who are lying in one spot for such a long period of time. And not unlike the Texas situation, their skin starts falling off. We've had people brought into our facility on the couch because the emergency medical technicians were fearful of trying to extricate them from the furniture.

I have seen people—I have dogs, many of us have dogs—and I'm always amazed at how blase people can be about their elderly loved ones or in a paid situation. We've had people who will stay in one spot for long enough that their skin starts breaking down. We talk a lot about bedsores or decubiti—these are things that take at least days, probably weeks, to months, to develop. It involves a situation where one individual will lie in one spot and isn't turned. They may be on a firm surface. And I'd suggest to you that if you have a dog that is lying in one spot to the extent that it's tissue starts rotting, you do something—you know, you'd know if there was a problem.

We have people in a home situation who I think really are trying to help care for their loved ones, but they just don't know what to do. I'll show you some slides of the ulcers. One of our frustrations in a hospital setting is there are a lot of devices that are available to prevent bedsores but they are not reimbursed under Medicaid or Medicare, and they can run anywhere from $20 to $100 a month, but you can't get them until the bedsore's there, and then it's really too late. It doesn't make sense.

Every time we try to send someone from the emergency department back into their home situation—and I'm not talking about the situations where there have been the kind of assaults that we've heard about here—but just a family caregiver who is trying to help the individual but doesn't have the educational or financial resources, there's no help for them. We have to let gross atrocities develop before we can gain some aid for the people.

Exploitation is another thing which I know Scott alluded to as a phenomenally common problem. We're in the rust belt and we have a lot of people who are laid off; and the typical scenario is we have a mom and dad who work, usually dad dies. The son gets laid off; usually has been accustomed to living beyond their means; frequently have a drug or alcohol problem; and they move into the home with mom. A lot of times there's some little kids in the house, too.

Mom starts getting progressively more debilitated. And as opposed to the child situation where our kids grow and start sleeping through the night and start taking care of themselves; the elderly deteriorate.

Our good health care, our expensive medical resources, have made it so that we all are living longer now, but we're also developing a large population of dependent and debilitated elderly.

We'll have an individual, an elderly lady living at home, getting confused; up during the night; not eating well; getting malnourished, getting dehydrated. The family caregiver may call the doctor and say, mom's up at night. The doc may prescribe a lot of medications. Mom ultimately becomes more confused because the elderly don't tolerate these medicines; and not infrequently, violence starts happening. They slap her. They push her around. They tie her to chairs and beds. She gets more debilitated. She's stuck in one spot and she starts rotting. It's a dreadful problem and it's extremely common.

We also have seen a fair amount of sexual abuse. And, unfortunately, it took us a while to become sensitized to it and start looking for it. I have a couple of cases I can tell you about.

One of our big frustrations in the health care situation is that we can take care of them internally—we lose money every time we do. And as soon as we place them back in their environment they're back at risk.

Our community has seven Adult Protective Service workers. They are the proverbial boy with their finger in the dike. It's just an enormous problem.

I think I'll show you some of the slides.

[Slide presentation.]

Dr. PARKINS. Now as I said, we have about 30 cases a year. We've been doing this for about 6 years. We have a phenomenal number of slides and the slides that I brought I've sort of selected because they typify the problem but also—unfortunately, maybe I made an error, but I took out some of the more horrible slides because they are so offensive, and I also left out any slides that have faces because we try to protect our victims' identity

This was our first case. This was a lady—and this demonstrates the fact that this is not a situation that occurs only to people that are poverty stricken.

This woman's husband had died less than a year prior to the time that we got her and had left her in excess of $200,000 and a paid-for home. She had family members move into the home to take care of her. She developed Alzheimer's. When we got her she was in a coma. She had been excessively medicated. She hadn't been fed. She hadn't been hydrated. Two days at our facility, she was alert again. She was confused because of her underlying disease, but it wasn't the necessary coma situation at all.

Her money was on direct deposit to the caregiver's account. They had exhausted the entirety of the $200,000—she was also receiving Social Security and pension benefits. She had been physically abused. These are bruises on her legs. Where bruises on the top of her feet—there's no reasonable mechanism for that unless you drop something on her. However, she was bedridden so there's nothing that could have been dropped on her. Bruises on the bottom of the feet. Again, you don't get bruises on the top and bottom of the feet from a benign situation.

She had bruises on her face. She had bruises on her chest. And we're embarrassed to say that she also had bruises around her vaginal area which we subsequently, after our nurses dutifully cleaned her up and took good care of her, found out it was because a mentally handicapped nephew that was living in the home had been frequently sexually abusing this lady.

As I say, a couple of days after we got her, she was awake. She was potentially placeable at that time but it took us 8 months to place her, because of the many problems that she had, in the absolutely ridiculous system that we have for placing these people.

This doesn't show well at all—it's a fracture. Let me see if the other one will show better. If you look over toward the right you can see sort of a ball. That's the top of the humerus or the arm. Just below you see a fairly acute angle which is where the arm is broken. The thing that's dramatic about this is that this was a lady who had no reported injury. She was in for another reason and we noticed she wasn't using her arm. The mechanism of injury for this kind of thing would not be a simple fall. This is something where she had apparently been jerked around to such a degree that her bone broke. And, again, the lady wasn't able to give a reasonable history, and the caregivers denied any involvement or any knowledge of what happened.

These are bruises on the lady's arm. She was being cared for by her husband. They had a long history of family conflict, which is not atypical for these situations. They shouted and slapped each other around for decades.

When we first started staffing this lady, we talked to the private doctor who said, don't worry, that there's family dynamic, it's no big deal. She came in with these bruises on her arms. She also had an extensive bruise going from the middle of her abdomen—from the belly button down to her knee, including her crotch.

She told us initially that she had stumbled against a chester drawers—absolutely impossible. She was protective of her husband. She was fearful of him and she was fearful of being moved to an extended care facility. These people are extremely reticent to come forward for help. They are extremely fearful that the alternative may be worse, or that the retaliation will be so horrible.

This is another example of the bruising. The individual had grabbed her—you get these circular lesions from the fingers where her husband had grabbed her and was moving it around, and then she bled into her skin.

This is a bedsore. This is an individual who came from home. He had made his wife promise not to take him to the hospital. The wife was doing the best she could. Bedsores are deceiving because there's a lot of dead tissue underneath before you get the changes in the skin.

Also, you can see his feet are swollen—I hope you can see his feet are swollen—and that speaks to the fact that he wasn't getting enough protein to keep his liquids in the spaces where they belong, so they start oozing out into the tissue under the skin.

This is another bedsore. This is in an elbow; and this again demonstrates the fact that any place where something relatively firm, a bony prominence, rests against a body or a piece of furniture, it will start to break down.

And, again, this is on the rib cage where that elbow had been pressing up against the ribs. So we had sores both on the elbow and the rib from the pressure of being left in one place for such a long time.

This is again the same individual.

This is a wound that was on the hand that's partially treated. These things are treatable. It costs money. It's much easier to prevent them. And, again, you think how simple it is to just pull your hand out. You know, we sit here, we get bored and we started moving around. These people are so frail and so weak, they can't even move to the extent of protecting their skin.

This is a burn, as if somebody had thrown hot coffee on this person and neglected it; didn't seek care. Now the burn is extremely infected. The person had a very protracted course in treatment.

This is another view of the burn. These are on the legs.

This is a bedsore. This lady came from an extended care facility. Her head is up to my left and her feet down here. This bedsore went through to her rectum. It is down to the bone, where there was bone, and went through to the rectum. And despite extremely aggressive surgical treatment, she died. She was in an extended care facility. They could not put her on the preventive devices because they're not paid for until the sore develops.

The other thing about that is that she had a physician taking care of her who hadn't been educated to the extent to recognize these things are preventable, which is another personally, professionally frustrating thing for me.

This fellow is the brother of an appeals judge in Ohio. He was a recluse and eccentric. He lived in a house with a wood burner for heat. He had several, probably thousands, at least hundreds of bunnies running around his home. The neighbors had called several times to various agencies trying to get someone to go in to take care of this fellow.

When finally they were successful, we found this gentleman to have had burns that he sustained on his legs from getting too near his wood burner, in which he was burning newspapers. He had no running plumbing, either.

Down by the foot, on the lower foot, there's sort of a circular area—and I don't think it shows much better on the next one—you can see that circular area on the right foot. Those little white things are maggots. He had recognized that he had a problem and tried to clean his own wounds, using Comet.

He did well. He had family resources which were able to be kicked in once the appropriate contacts were made. The frustration was that it took the development of this kind of a problem before help could be gotten for him.

This is a lady who was being cared for by a family member. She came to us in coma. She had not been adequately fed or given fluid. Her skin is soft and kind of white and smooth looking because, again, she's not getting enough protein to keep her nutrients where they belong. Her skin hadn't broken down. It had a bit on the hips but not to a terrible degree. She became alert fairly quickly with hydration.

But, again, we were faced with the difficult problem of placement for her, or trying to get help for her in the home.

This is a bedsore. This goes through, again, to the rectum. The big sore on the bottom—that white tube is a capitur into the bladder. The head is up to my left.

This person weighed about 50 pounds. This is the chest. The feet are to my left. The head's up this way. That hole is over the ribs. We could see the muscles in between the ribs contracting every time this lady took a breath.

This is another view of her. There's clearly malnutrition here.

She went to a community hospital where they weren't equipped to take care of her. She needed a tertiary care center like ours. She came from another State and was refused admission to three hospitals before we accepted her because she had no financial resources. Now, we're not supposed to say that, but we know that that was the case.

This doesn't show well at all. There's a line that goes down the center. This lady was living at home and had a diaper in place, and the family changed it so seldom that when we took the diaper off, skin came off with it. She had an enormously—she had like a terrible diaper rash as well, but we try not to show those shots.

This is an individual who came again from an extended care facility, and his elbow's breaking down. He had bruises on his legs. We're not sure of the mechanism on those. We have no clear explanation because he was essentially bedridden as well. Then he had a horrible sore on his bottom. Now, this had been under treatment for a period of time, and this is how they look when they look good. So this is one that's resolving in the hospital situation. We'll spend easily $30,000 resolving an ulcer like this. And a lot of the people die.

This is another sore which was on his heel. Every place where he was in contact with a bed or mattress, his skin started breaking down. This is just a toe. It's just a small ulcer that's developing. This was a lady who was brought in by her daughter. She had bruising of her face where the daughter had hit her. We try not to show facial shots. The daughter and the emergency department said, please help me. I'm hitting mom. I'm tying her up. I don't know how to care for her. You've got to help me. And our experience is a lot of our caregivers really want help. The resources just don't exist.

This is an easy one. This individual was an elderly man—and this is my last one—it's an elderly man who lived at home with his son. He had been losing weight progressively. He had dentures which no longer fit so he wasn't able to eat any solids. He had been urinating blood for at least a week, possibly longer, and no health care was sought for him.

The son, while intoxicated, took a knife to his dad. This is his hand. The white gloss—it's all bloody—is right by a knuckle where his joint was opened up. He had seven major lacerations on his head where his son had hit him repeatedly on the head. He had scalding water thrown on him. His head is up to my left. This is his chest. The pink stuff is where skin is peeling away, both on his chest and on his arm, which is being held onto by a gloved hand down at the bottom. He had his knee opened up by a knife. The joint was totally disrupted, and he had multiple lacerations on his arms.

The reason I say this is an easy case is this is clearly criminal, and the son was prosecuted and went to jail. The bad part is, this gentleman had worked. He had some retirement funds. He had Social Security. He hadn't been given his medication. It turned out he had prostate cancer; that's why he had been urinating blood. No help was gotten for him by his caregiver for any of these things prior to the time that he got so debilitated and so irritating that his son assaulted him like this.

The man, when we got him, was a little bit confused, but really a delightful fellow; not a difficult patient at all.

Those are all the slides that I brought with me.

[The slides presented by Dr. Parkins have been retained in Subcommittee files and may be viewed upon request.]

Dr. Parkins. I think the key point that I'd like to bring out is one of our frustrations is early on we may detect problems; we recognize there's a bad family dynamic; we recognize that the family needs help. They need someone to come in and give care for a period of time during the day. They need the availability of Adult Protective Services. They need reimbursement for some of the aids which will help prevent the development of some of these horrible wounds. They need help with the nutrition. They need good monitoring.

We need physicians to be educated to these problems so we pick them up earlier. And we need coordination of our benefits, both on the State level and nationally.

I very much appreciate your attention to this. This is something that's been extremely frustrating for us for a number of years, and is an extremely important problem.

We are all getting older. We will all either die or be disabled, and we are at risk of being victims.

Chairman Roybal. Thank you, Dr. Parkins.

[The prepared statement of Dr. Parkins follows:]

STATEMENT OF
SUE M. PARKINS, M.D., F.A.C.E.P.
MEDICAL DIRECTOR
ADULT PROTECTION TEAM
ST. VINCENT MEDICAL CENTER
TOLEDO, OHIO

I am, by training, an emergency physician who has been the Physician Director of the Adult Protective Team at St. Vincent Medical Center, in Toledo, Ohio, for the last several years. Our team is apparently unique, or at least was at the time we started and the first few years of its existence, in that it is a multidisciplinary approach to the management of elder abuse. We are all strictly voluntary on the team and do our adult protective work as part of our normal hospital responsibilities.

If an individual presents to the Medical Center, either through the Emergency Department or directly to the floor, and is identified by (usually) an RN as being suspicious for abuse, neglect, or exploitation, a report form is filled out and Social Services are contacted. We have a specific Social Service worker who is designated as Adult Protective Team worker, however, in that individual's absence other social workers can fill in. The form is filled out and, if deemed appropriate, Adult Protective Services, the Attorney General's office, or nursing home ombudsman is notified.

Each case is staffed by the Adult Protective Team whose members include the social worker (other social workers that have key cases if a problem), myself, an enterostomal therapist, a nutritionist, key RNs from the teaching floor and Emergency Department, and several others.

As part of the overall case management, discharge planning is a key component which is, of course, a social work responsibility and exists in many cases that do not involve elder abuse.

We have maintained a record of the cases that we have staffed and their results and have obtained slides where deemed appropriate. The cases break down into the following areas: abuse, neglect, and exploitation. I have some slides to demonstrate each of these specific areas.

From the abuse standpoint, we have an individual whose slides reveal burns and lacerations. He was also malnourished and dehydrated, his dentures no longer fit, and he had prostate cancer and was urinating blood without any help being gained for him.

Under the neglect heading fall a number of decubitus ulcers or bedsores. The unfortunate thing about these is that they are all potentially preventable. There are anti-pressure devices available which cost anywhere around $400 which could prevent the development of bedsores. These, however, are not reimburseable under Medicare until a bedsore has developed. At that point, we are looking at spending closer to $20-30,000 to resolve the bedsore before being able to put them on the anti-pressure device. This is particularly frustrating because of the potential for prevention. The majority of our neglect cases seem to arise out of the homes or extended care facilities where the individuals doing the care giving are financially strapped and do not have the appropriate committed resources to help get care for their elderly.

Exploitation, of course, is not a visual problem. Our first case was a classic example of exploitation. This lady had her Social Security and pension checks on direct deposit to her abusing caregiver. Subsequently she ended up with dehydration and malnutrition, however, she also had been sexually and physically abused.

The key needs that we are seeing are working toward early detection and prevention which will require an expansion of education and an expansion of the resources available to the Adult Protective Service workers. We will also require a liberalization of the financial support available to both prevent and treat injuries and for routine medical health care so that these elderly individuals are not sent home in a compromised state.

I think it is very important to develop a coordination of these efforts on a state by state basis by generating federal guidelines. We need some consistency from state to state so that we do some realistic data gathering to truly assess the magnitude of the problem and to put in place the appropriate resources.

Thank you.

Sue M. Parkins, M.D., F.A.C.E.P.
Medical Director
Adult Protection Team
St. Vincent Medical Center

SMP/lk

Chairman **Roybal**. The Chair will now recognize Dr. Toshio Tatara, the Director of the National Aging Resource Center on Elder Abuse.

STATEMENT OF TOSHIO TATARA, PH.D., DIRECTOR, RESEARCH AND DEMONSTRATION DEPARTMENT, AMERICAN PUBLIC WELFARE ASSOCIATION, AND DIRECTOR, NATIONAL AGING RESOURCE CENTER ON ELDER ABUSE

Dr. **Tatara**. Thank you, Mr. Chairman. Good morning everyone and the members of the subcommittee. My name is Toshio Tatara, the Director of the Research and Demonstration Department at the American Public Welfare Association.

Since October of 1988, I have served as the Director of the National Aging Resource Center on Elder Abuse, which is operated by a consortium of three organizations: APWA, the National Association of State Units on Aging, and the University of Delaware. Today I am here on behalf of the National Aging Resource Center on Elder Abuse to provide you and the other members of the subcommittee a brief summary of the findings of the Center's survey of States on the incidence of elder abuse that occurs in domestic settings. On behalf of APWA and the two other organizations that participate in the consortium, I would like to thank you, Mr. Chairman, for inviting me to appear before your Subcommittee on Health and Long-Term Care.

In the interest of time, however, Mr. Chairman, I will make my comments very brief and will be happy to answer your questions.

Mr. Chairman, we have a witness here at the table, Mr. Jones, and we have heard about many victims of abuse and neglect, exploitation, this morning. Take Mr. Jones' case for example, that is only one of the thousands of elder abuse cases that are handled by Adult Protective Services agencies every day. There are many other Mr. Jones in the country who are abused or neglected in their own homes.

In one sense, Mr. Jones is lucky, because his case was reported to the proper authorities and appropriate measures have been taken by trained experts. Elder abuse still is largely hidden and, therefore, is underreported. In fact, it is far less likely to come to the attention of authorities than child abuse—that we have heard many times. We found that to be true.

One recent study found that only 1 out of 14 cases of elder maltreatment was actually reported. Therefore, it is clear to those of us who study elder abuse that the reported cases represent only the tip of the iceberg.

Mr. Chairman, the National Center's survey of States reveals that nationwide about 140,000 reports of elder abuse, neglect and exploitation were made during fiscal year 1988. That number of reports increased steadily from previous years. These are reports of elder maltreatment that occurred in domestic settings, and they do not include those which are reported by institutions

Because a large number of elder abuse cases were not likely to be reported, as I mentioned earlier, it can be assumed that these 140,000 reports represent only a small fraction of the tens of thousands of elder abuse incidents that actually occurred in 1988. In fact, our center estimates that there were nearly 2 million reportable cases that occurred during that year but only a small fraction was reported.

Thank you very much for the opportunity for us to release the report at the same time your committee's report is being released, Mr. Chairman. This report has been submitted to your committee along with my testimony for its record.

The report contains some of the domestic elder abuse statistics for fiscal year 1986, fiscal year 1987 and 1988 that the National Center has collected from States.

In addition to the national estimates for the Council of Domestic Elder Abuse reports I have just mentioned, this publication also contains information about the types of domestic elder maltreatment that occurred and the identities of perpetrators and other survey findings. As I mentioned, a copy of the report has been submitted to your subcommittee and they're being released today nationwide.

This will conclude my remarks and I'll be happy to answer any questions.

[The prepared statement of Dr. Tatara follows: see Appendix III, p. 308 for report submitted by Dr. Tatara.]

APWA

AMERICAN PUBLIC WELFARE ASSOCIATION

TESTIMONY OF TOSHIO TATARA,
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AMERICAN PUBLIC WELFARE ASSOCIATION (APWA)
AND
DIRECTOR, NATIONAL AGING RESOURCE
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ON BEHALF OF NARCEA

BEFORE THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
SELECT COMMITTEE ON AGING
U.S. HOUSE OF REPRESENTATIVES

HEARINGS ON "ELDER ABUSE:
A DECADE OF SHAME AND INACTION"

MAY 1, 1990

NATIONAL AGING RESOURCE CENTER ON ELDER ABUSE (NARCEA)

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Good morning, Mr. Chairman and members of the Subcommittee. My name is Toshio Tatara, director of the Research and Demonstration Department at the American Public Welfare Association (APWA), a 60-year-old non-profit, bipartisan organization that represents the human service departments in 50 states, the District of Columbia, and the U.S. territories; several hundred local public welfare agencies; and more than 5,000 individuals across the country. APWA has been on the forefront of efforts to help enhance public awareness and improve state and community responses to elder abuse. On the national level, the National Council of State Human Service Administrators, the national organization of the state human service executives operating within APWA, has expanded one of its standing committees to address issues related to adult and elder services. Further, APWA has formed a partnership with the National Association of State Units on Aging (NASUA) to conduct research and information dissemination projects on elder abuse. The U.S. Administration on Aging (AoA) has recognized APWA's leadership on this critical issue by awarding APWA a grant (NO. 90-AM-03321) to establish the National Aging Resource Center on Elder Abuse (NARCEA).

Since October 1988, I have served as the director of this National Center, which is operated by a consortium of three organizations: APWA, NASUA, and the University of Delaware. Today, I am here on behalf of the National Aging Resource Center on Elder Abuse to provide you and other members of the Subcommittee with a brief summary of the findings of NARCEA's recent survey of states on the incidence of elder abuse that occurs in domestic settings. On behalf of APWA and the two other organizations that participate in the consortium, I wish to thank you, Mr. Chairman, for inviting me to appear before your Subcommittee on Health and Long-Term Care.

Mr. Chairman, I would first like to share with you a true story about the insidious problem of elder abuse and the people who are its victims:

> Mrs. D., a quiet, 83-year-old woman, understands pain and terror. She has lived a nightmare of fear that is unimaginable to most of us. Her ordeal began with frequent drinking bouts and violent shouting matches between her 84-year-old husband and 52-year-old son, both of whom have been alcoholic for most of their adult lives. The three live in a small, cramped mobile home near the outskirts of a large, midwestern city.
>
> As time progressed, these drinking episodes and arguments grew increasingly worse. Several times, Mrs. D feared for her life when her son hit her and her husband made no attempt to protect her. Then, one night, in a fit of rage, the son attacked her repeatedly: her arm was broken as a result. That night, he also assaulted a friend of Mrs. D's husband. Throughout these attacks, Mrs. D's husband stood by, helpless. He was too drunk and too terrified of his son to utter a sound or lift a hand in his wife's defense.
>
> In great pain, Mrs. D stumbled to a neighbor's home. She was taken to a hospital where the local Adult Protective Service (APS) Unit was notified. APS investigators found that the son also was stealing his father's SSI and Social Security checks, the only income the family had to live on.

In his defense, the son said that he resented his mother because of the beatings he received from her as a child. Mrs. D contended that the beatings were only "spankings."

To protect Mrs. D, a caseworker placed her in an adult foster home and began counseling sessions with Mr. D and his son. Two months later, police found Mrs. D on the street, apparently trying to walk several miles to the family's mobile home. The caseworker was notified. Mrs. D told her that she "felt bad about the whole thing" because she "might have done something wrong to cause this" and wanted to go home. The caseworker and her supervisor then decided that Mrs. D could return home if the family received intensive alcoholism counseling.

The family's income is now safe, with all checks sent to a representative payee. In addition, the family regularly receives alcoholism counseling from experts. No more episodes of violence have occurred, although Mr. D and his son still drink. APS workers regularly monitor the home to ensure that Mrs. D is safe, and the drinking problems of Mr. D and his son are under control. **[An actual case taken from the APS case records of the Bureau of Adult Services, the Ohio Department of Human Services.]**

Mr. Chairman, this is only one of the thousands of elder abuse cases that are handled by adult protective service and aging agencies every day. There are many other Mrs. D's, in the country, who are abused or neglected in their own homes. In one sense, Mrs. D is lucky because her case was reported to the proper authorities and appropriate measures have been taken by trained experts.

Mr. Chairman, elder abuse still is largely hidden and, therefore, is underreported. In fact, it is far less likely to come to the attention of authorities than child abuse. One recent study found that only one out of 14 cases of elder maltreatment was actually reported. Therefore, it is clear to those of us who study elder abuse that the reported cases represent only the tip of the iceberg.

Mr. Chairman, the National Center's survey of states reveals that, nationwide, about 140,000 reports of elder abuse, neglect, and exploitation were made during FY 88 and that the number of reports increased steadily from previous years. These were reports of elder maltreatment that occurred in domestic settings and do not include those that were reported by institutions. Because a large number of elder abuse cases are not likely to be reported, as mentioned earlier, it can be assumed that these 140,000 reports represent only a small fraction of the tens of thousands of elder abuse incidents that actually occurred in FY 88. The National Center estimates that there were nearly 2 million "reportable" domestic elder abuse incidents, nationwide, that year.

Mr. Chairman, I would like to share with you and other members of the Subcommittee a "Summary of Findings" from the National Center's report entitled, Summaries of National Elder Abuse Data: An Exploratory Study of State Statistics. This report contains summaries of the domestic elder abuse statistics for FY 86, FY 87, and FY 88 that the National Aging Resource Center on Elder Abuse collected from state adult protective service and aging agencies across the country. In addition to the national estimates for the counts of domestic elder abuse reports, this report contains information about the types of domestic elder maltreatment that occur, the identities of perpetrators, and other survey findings. A copy of the report is submitted to the Subcommittee for its records, along with this testimony. Additionally, copies of the report will be disseminated to states and organizations involved with elder protective services.

SUMMARY OF FINDINGS

- The national estimates for the counts of domestic elder abuse reports developed by the National Aging Resource Center on Elder Abuse (NARCEA) are as follows:

  FY 86 . . . . 117,000 reports
  FY 87 . . . . 128,000 reports
  FY 88 . . . . 140,000 reports

- From FY 86 to FY 88, there was a steady rise in the number of elder abuse reports, nationwide -- an increase of 19.7%. These reports include only those of elder abuse, neglect, and exploitation in domestic settings.

- While the true incidence of elder abuse is not known, it is believed that the reported cases represent only the tip of the iceberg. NARCEA estimates that, nationwide, there existed greater numbers of "reportable" domestic elder abuse incidents than those that were actually reported. These estimates of "reportable" incidents are:

FY 86	1.6 million
FY 87	1.8 million
FY 88	2.0 million

- In FY 88, the domestic elder abuse reporting rate among urban states (N = 33) was greater than that of rural states (N = 17), as follows:

Urban states	3.77 reports per 1,000 elders
Rural states	2.60 reports per 1,000 elders

- Information about specific types of domestic elder maltreatment that occurred in 24 states during FY 88 is available, as follows:

Physical abuse	26.3%
Sexual abuse	1.6%
Emotional abuse/neglect	11.0%
Neglect	37.2%
Financial/material exploitation	20.0%
All other types	2.8%
Unknown	1.1%

- Based on FY 88 data provided by 15 states, NARCEA identified the perpetrators of domestic elder abuse, as follows:

Adult children	30.0%
Grandchildren	1.9%
Spouse	14.8%
Sibling	1.7%
Other relatives	17.8%

Service provider	12.8%
Friend/neighbor	10.0%
All others	9.4%
Unknown	1.5%

o Available data show that older women are more likely to become victims of domestic elder abuse, as follows:

	FY 86	FY 87	FY 88
Ratio of female victims to male victims	1.65	1.63	1.79
Ratio of female elderly to male elderly in population	1.36	1.36	1.33
No. of states:	18	22	18

o The elder abuse substantiation rates were computed on the basis of data from 19 states, as follows:

	FY 86	FY 87	FY 88
Substantiation rate	54.2%	52.9%	53.8%

o Using FY 88 data, NARCEA calculated the elder abuse reporting rates for states with mandatory reporting systems and those with voluntary reporting systems, as follows:

	Mandatory System	Voluntary System
Reporting Rate	3.96	2.23
	(N = 43)	(N = 7)

* Number of reports per 1,000 elderly people (60 years of age and older).

Mr. Chairman and members of the Subcommittee, on behalf of APWA, NASUA, and the University of Delaware, which participate in the operation of the National Aging Resource Center on Elder Abuse, I thank you very much for inviting me to testify on one of the Center's activities, "elder abuse data collection and analysis." The National Center conducts many other activities, including "training of adult protective and aging service workers," "provision of technical assistance to agencies," "publication of the quarterly newsletter, NARCEA EXCHANGE, and research reports," and "dissemination of information about the elder abuse literature through an automated document search and retrieval system." Across the country, there are hundreds of agencies, which are just like the one that helped Mrs. D and her family, providing protective services to victims of elder maltreatment and at-risk elderly. In addition to expanded funding, these agencies also need worker training, information about successful program models, and opportunities for networking with other agencies. In our small way, the National Center hopes to assist these agencies which, we believe, are on the forefront of efforts to combat elder abuse, which the late Representative Claude Pepper appropriately called a "national disgrace."

Finally, we are grateful to AoA for its funding support for NARCEA and will continue to work closely with officials of AoA and other professionals involved with elder abuse issues across the country to effectively achieve the objectives of the Center. Thank you.

Chairman ROYBAL. Thank you, Dr. Tatara. We will now go into the 5-minute rule. Each one of us will ask questions for 5 minutes. I will start out the series of questions and I'll hold myself to the 5-minute rule.

The first question is to Mr. Jones who has stated that he had a restraining order against his son since 1986. Were you abused after the restraining order was issued?

Mr. JONES. Yes.

Chairman ROYBAL. And that abuse continued until when, Mr. Jones?

Mr. JONES. Pardon?

Chairman ROYBAL. The abuse continued until what time, or when? Continued until he was incarcerated?

Mr. JONES. Yes, off and on, I'd say.

Chairman ROYBAL. So the court issued a restraining order but the abuse did in fact continue and then finally the man went to jail.

Now, Mr. District Attorney, this restraining order was in 1986 but the person that was involved, the son, did not go to jail until March of this year.

Why did it take so long?

Mr. HARSHBARGER. In this case it's pretty simple, though tragic. Mr. and Mrs. Jones specifically would have declined to prosecute if their son was going to jail. We had a suspended sentence based on a December, Christmas Eve, incident in 1988 which was the most violent incident. A suspended sentence was given by the judge, at the insistence of Mr. Jones and his wife.

When Mr. Jones finally felt that his paternal instincts had to give way to his safety, we got the jail sentence which we believed was appropriate and we have an additional suspended sentence on top of that.

It was our desire to honor the requests and desires of the parents rather than to incarcerate until the most recent incident in February of his year. It's one of those cases where it is not the fault of the court or any government agency. Those orders existed and they were enforced but the parents themselves declined to seek the ultimate sanction.

Chairman ROYBAL. Would you say, then, that it is very difficult to prosecute a case of elder abuse?

Mr. HARSHBARGER. It is very difficult for a couple of reasons. The physical abuse cases such as Mr. Jones—with reluctant witnesses—and the neglect cases shown by Dr. Parkins in her slide presentation, where there probably was only one clear case for prosecution in terms of overt criminal acts by the perpetrator, exactly the common difficulties which prosecutors face.

Our problem prosecuting with reluctant witnesses is the same as we have getting cases reported: victims deny anything happened and they decline to participate in the criminal justice process. The reasons are basically very simple: they face retaliation; the people that they are asked to testify against are people they love and may be their only tie to the world—and they fear the loss of that connection.

On the other side we have been able, through training and working with victim witness advocates, to keep more witnesses in the process. I don't want to let prosecutors off the hook on this. That is, I think we've learned to do a great deal with child victims that we never before could do. And we need now to intensify the process of learning how to work with older witnesses, as well.

But having said that, I still think there is a high degree of denial and of lack of willingness to participate by the victims. But far too often, I'm afraid, Mr. Chairman, we use that as an excuse not to prosecute cases that we might otherwise pursue, more aggressively and sensitively, if they did not involve elderly victims.

Chairman ROYBAL. Ms. McLaughlin, you reported that there were 22,000 reports of elderly abuse in Texas, and that upon investigation, only 18,000 were found to be valid. That's 82 percent, you stated, of the 22,000 that were reported.

Of those 18,000 that you found to be valid, how many actually were taken to court and how many were found to be guilty and sent to jail?

Ms. MCLAUGHLIN. In Texas, we have not been very successful in prosecution of alleged perpetrators. It has only been recently that we've enacted State legislation that makes crime against the elderly a crime. So that it has only been a few cases at best in the last couple of years that we have prosecuted that have been successful.

Chairman ROYBAL. One last question on this subject matter, because it's of great interest to me, is the legal status of an elderly abuse case.

Do you have to find beyond a reasonable doubt that the abuse did in fact take place?

I'm asking District Attorney Harshbarger.

Mr. HARSHBARGER. The clarification I'd like to make is this: We prosecute cases like Mr. Jones' son as assault and battery or assault and battery with a deadly weapon. Abuse of the Elderly is not a separate crime in traditional criminal States.

In the financial exploitation cases I mentioned, Mr. Chairman, we prosecute for fraud, larceny by check, or the traditional forms of crimes. We do not have the separate crime in Massachusetts yet. I believe Texas has just begun to use the statute, where neglect of the elderly resulting in bodily harm or death is a crime. That statute has not been tested. But the acts of omission are most definitely the most difficult cases to prosecute.

Chairman ROYBAL. Thank you.

My time is up.

The Chair now recognizes Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

You all have described an ugly picture really of national shame. I think what is most frightening to me is that while elder abuse is up, programs to prevent it, and to detect it, and treat it are down.

You touched on, Ms. McLaughlin, how long it took in Texas to get a prosecution statute through. Let me start perhaps with you.

Why have politicians dawdled in the face of this national outrage? We knew about this years ago. The evidence was clear; reports were being written years ago. Why have politicians at just about every level of government dawdled in the face of this outrage?

Let me start with you, Ms. McLaughlin.

Ms. McLaughlin. It's really difficult for me to respond to why politicians have dawdled the way that they have.

I will say this, and that is, I think that in Texas social services programs have never taken a very high priority. And programs for the elderly have not deserved the kind of attention that they certainly need. They have needed attention and they haven't gotten it.

Mr. Wyden. Is part of the problem that this is just hidden? I mean, this is always described as a silent tragedy. One way to jump-start the political system is just to do as we are today trying to bring it out in the open.

But I'm looking for reasons why it has been so hard, given the fact that this evidence has been out there for years, to get politicians to go after it.

We've got a section of the Older Americans Act, for example, that deals with elder abuse—it's some authorization. But it's just lip service until we get the money. There has been no appropriation. So if any of you can give any other reasons of why it has been so hard to get people in politics to take this seriously, I think it would be helpful.

Mr. Harshbarger?

Mr. Harshbarger. While I am a professional prosecutor, I am also an elected official and understand the sometimes unfortunate realities of what it takes to move people in politics to take action.

In the child abuse cases, it took horrible tragedy to uncover the reality that children, 95 percent of the time, were far more at risk from their fathers, stepfathers or live-in boyfriends than they were from the traditional stranger jumping out of the bushes.

Similarly, we have, for too long, lived under the myth that older Americans are more likely to be victims of violent crime or street crime by strangers.

My experience in this area is that the House Select Committee on Aging has been one of the few Government bodies nationally to at least attempt to address this issue. And these individuals that are here with me on the panel have been planters in the vineyard. Dr. Parkins' efforts have been extraordinary. And I certainly don't want to take law enforcement and the prosecutors off the hook here, but we have had a very hard time in this field working with the medical community in terms of multidisciplanery cooperation

Complicating this whole area are issues of liability and the presumption that adults are legally competent. There is an important constitutional distinction. We have, as a matter of public policy, always been willing to be paternalistic regarding children, and to pierce the veil of secrecy in the interest of the children.

We are dealing with older Americans with a very important right at issue: their right to choose, their right to decide for themselves. And I think that to some extent there has been some concern about sacrificing that right. But beyond that, I fear it's going to take a tragedy such as the Sacramento boarding house case to move government to respond effectively and devote the necessary resources.

We have only acted when we see the terrible tragedy; not when we see the gradual violence.

Mr. Wyden. Any way you slice it, the principal tool we've had since 1980—the Social Service Block Grant—has been cut dramatically.

I am of the view that unless the Federal Government takes the lead, this job isn't going to get done. And you all have been very helpful to try to get us to jump-start the system.

Mr. Jones, one question, if I might, for you. Do you think your son is going to want to see you when he gets out of prison; and do you want to see him?

Mr. Jones. I'd certainly think he would want to see us, but he won't be able to because he's—one of the conditions of probation is that he won't be able to come to the house again for a long time. But naturally, we'd like to see him—naturally. We'd be very unhappy if he becomes a street person, very unhappy.

Mr. Wyden. Thank you. Thank you for your testimony. It's going to open a lot of eyes in this country, and I thank you.

Thank you, Mr. Chairman.

Chairman Roybal. Thank you, Mr. Wyden.

The Chair recognizes Ms. Oakar.

Ms. Oakar. Thank you, Mr. Chairman.

Let me just say to Mr. Harshbarger, you have been here before; and 5 years ago you were here and you endorsed the bill I introduced—a $10 million bill that would put elder abuse on the same parallel as other abuses like child abuse.

My friend, Mr. Wyden, has asked you the question why don't politicians pass these kind of pieces of legislation. I wanted you to know that for this $10 million bill everything is relative, but it's a small amount compared to the billion dollar bills that sail through this Congress. We have a grand total of five cosponsors.

I think we should be ashamed of ourselves, that we have passed part of it as an authorization, as Ron said, but we haven't appropriated the money for it. So maybe this kind of a hearing will get the American people a little enraged and get them to clamor after some of the members in the administration to pass a bill.

It did take the Animal Protective League, you may recall, around the turn of the century—reported the first child abuse in this country officially. It only took us 70 years to pass a child abuse bill.

I would hope that we can pass an elder abuse bill a little bit sooner. If I sound frustrated, it's because I, like others, certainly am.

I wanted to ask Mr. Jones, you mentioned and throughout this testimony I have heard rationale given related to why this abuse is so prevalent. And one of the streams of reason seems to be alcoholism. That's not the only reason but it seems to be done by alcoholics. You mentioned your son was an alcoholic. And I think you mentioned in your testimony that when he wasn't drunk he didn't abuse you as much. Is that right?

Mr. Jones. Not as much, but he did abuse us when he was sober. If he didn't do it physically, he did it in a verbal way—harassed and everything.

Ms. Oakar. Did anybody ever try to get your son help, or did he ever try to go into a substance abuse treatment program of any kind?

Mr. Jones. The court ordered him to go to AA.

Ms. OAKAR. And he would get detoxed and he would get some treatment before he went to AA or at the same time he went to AA, did he? Did he ever do that?

Mr. JONES. The court ordered him to go to the VA hospital in our State. He went there, and I think he was there about a half a day—that was Christmas Eve. He was kicked out because he was caught trying to bring liquor into the VA. They were going to help—they were supposed to help him.

Ms. OAKAR. Dr. Parkins, you've seen all these cases in Toledo—it is one of the areas where you try to deal with this situation comprehensively.

What kind of outreach there is for the individual who does the crime, commits the crime? Do you try to treat those people as well or is that sort of a hopeless cause? Do we just give up on the kids?

Dr. PARKINS. In the criminal cases, of course, they're prosecuted; the vast majority aren't criminal cases. I had the one example of the woman who came forward and said, please help me.

We are very limited in our resources. We have internally, if they're admitted into the hospital, we have our social service people that can work with them. If they are not hospitalized, we have mental health workers who can potentially help them. But all of those resources are overburdened. We have family support groups that are available.

Ms. OAKAR. Let me just say this. All of you sort of indicated, and I think you hit it on the head—you were talking about prevention. Some kids you can't help, they're losers, and that's the way life is. They are abusers for whatever reasons.

But the fact is that we have not tackled the lobbies around this place; that's why the drug bill, the Omnibus Drug Act, has zero for treatment and education of alcoholism. That's why it's voted under a block grant and hidden and all that sort of thing.

It's not the only reason for elder abuse. But wouldn't it be wonderful if there was some treatment out there—if that was recognized as a national scandal—and we would have individuals who are caregivers who were free of alcohol and other drugs? Wouldn't that be tremendous?

But we don't have a national policy that says that's a problem in this country. I tell you, you ought to go after us for that, and the administration—and after us for allowing 10 years to go by, and more and more victims; and we can't even pass an elder abuse act.

Just one last question, Mr. Chairman.

Do you think your job would be easier as a prosecutor if you had the law on your side in terms of a national policy?

Mr. HARSHBARGER. Absolutely.

Let me just make one additional point. Eighty percent of the crimes of violence committed in this country—certainly in my county, which is a very diverse microcosm of the State and country-are committed by people who are under the influence of drugs or alcohol. And alcohol continues to be the most dominant, prevalent factor in every type of crime. It undoubtedly has had a dramatic impact, particularly in domestic violence cases, as well as in elder abuse cases.

I would, as a prosecutor, say that the best solution to crime in this country—and my argument in support of Congressman

Wyden's position—is drug and alcohol treatment, early intervention, home care, respite care. All of these cheaper support interventions are the best form of public protection.

And if we can't sell it any other way, let's simply sell it as tough people, prosecutors, saying, these aren't nice services being provided to people, these are essential forms of public protection and you pay now or you pay later in further victimization and dead people.

Ms. **Oakar**. We're trying to pass the Universal Coverage and Long-Term Care Act, 4352. The chairman has another bill, a very similar bill. And somehow, it all goes hand-in-hand, doesn't it?

Thank you, Mr. Chairman.

Thank you, Mr. Jones, in particular, for coming.

Chairman **Roybal**. Thank you, Ms. Oakar.

The Chair recognizes Mr. Richardson.

Mr. **Richardson**. Thank you, Mr. Chairman.

Mr. Hernandez, I'd like to ask you a question, if I could, and if you need any clarification, please let me know.

My question relates to elderly abuse problems being more of a hidden problem in the Hispanic community; more so in the Latino community than in other communities.

In other words, because of a strong sense of family, or perhaps because of a language barrier, is a Latino less likely to report abuse of his or her parents?

Mr. **Hernandez**. I think so. I'm hard of hearing.

Mr. **Richardson**. Let me ask the panel, what do you think about this problem?

Obviously, more funding, education, and outreach would help, I think everyone is agreeing on that.

Mr. Harshbarger, do you support the penalties of an elderly abuse problem not being reported?

Mr. **Harshbarger**. Yes.

Mr. **Richardson**. So that would be another law enforcement measure?

Mr. **Harshbarger**. I know I've had the benefit of a lot of time, but you've put your finger on something that is very important.

The failure to report by people charged professionally with that responsibility is a problem. In a child abuse case, my office prosecuted the headmaster at a private school for nonreporting. One prosecution sent the message. It didn't matter what the penalty was; it sent the message throughout the educational community and furthered the education process in a way that nothing else had done to that point.

Mr. **Richardson**. Dr. Parkins, Ms. McLaughlin, I'm talking about the Federal level; do we need a Federal agency to do this? Can it be done with the existing block grant system? Do we need a national center for elderly abuse, in your judgment?

Dr. **Parkins**. I would say from several perspectives. One thing is, in Ohio I had a case of an individual who came into our facility, who died shortly after arrival, who had been starved and got bedsores and rotted.

I talked to the local prosecutor who couldn't find anything in the statute upon which to base any kind of prosecution. So from that standpoint I think we need a Federal mandate.

We have failed miserably in our local attempts to deal with the problem. I think we need more direction.

I think that Scott has said that one of our big problems is detection. And the difference between the elderly and kids is kids get out and go to school; they are more energetic, they're more active. The elderly are basically a reclusive population. They're fearful of change, extremely fearful of any kind of change.

So we really need to be more aggressive about attempting to help them and supply some services to them. I would say unequivocally, yes, I think we need to come from a Federal standpoint on that.

Mr. RICHARDSON. Nobody has really answered the fundamental question, and that is, child abuse, a lot of attention is being dedicated to that.

Why not elderly abuse?

Dr. PARKINS. One of the problems we have is we don't have any uniform reporting. We can't scientifically answer the question about Latinos, because we don't have clear definition from State to State and we don't have any good reporting to be able to cause some of the statistics.

Mr. RICHARDSON. Do we need Federal preemption—Federal uniformity of existing statutes to start out?

Dr. PARKINS. Yes, I think so. We are a youth-oriented population. We love vitality. We love exercise. We love the youth; and we have a negative attitude about the elderly anyway. So I think that's one of the reasons why there's been a failure of support. Kids are cute, cuddly, and pathetic. Elderly people are old and wrinkled and debilitated.

I think we have to recognize that we need to be more aggressive about helping them.

Mr. RICHARDSON. Ms. McLaughlin, answer my question on the Latino community. You're a Texan, aren't you?

Ms. MCLAUGHLIN. Yes.

Mr. RICHARDSON. Is this true, do you see Latinos, minorities that are having difficulty with the language perhaps because of a strong sense of family, or shame, holding back and not reporting these?

Ms. MCLAUGHLIN. I think it's particularly difficult for the Hispanic culture to come forward primarily because they are so family oriented; and to admit that there's a problem in their family is extremely difficult for them.

I also think that in Texas it's difficult for all the families to come forward. But in the Latino family, language is often a barrier. We have bilingual workers who are assigned to Latino and Hispanic families and they do converse with them in their native tongue. However, there are some problems and some barriers just by virtue of that.

Mr. RICHARDSON. My last question is to Mr. Jones. You've heard a lot today from politicians, from advocates, from somebody that was very close to you—you've heard the concern about this issue. If there's one thing that you want us to do here in the Congress, what do we need to do to prevent cases like yours from happening again?

Mr. JONES. I really don't know how to answer that.

Mr. RICHARDSON. All right.

Thank you, Mr. Chairman.

Chairman ROYBAL. Thank you, Mr. Richardson.

We will of course, pursue the answer to that question as we go along. But I'd like to ask Dr. Parkins some questions with regard to the medical profession.

In your opinion, Doctor, is the average physician able, first of all, to recognize signs of physical elder abuse?

Dr. PARKINS. No. Again, it has been extremely frustrating to me professionally. I feel that we are negligent as a group in picking up elder abuse and I think there are several reasons. One is, I don't think that physicians have been sensitized to recognize what's going on.

I have, myself, spoken to physicians who will say, when you get old you shrivel up and your skin breaks down.

The truth is, now with our medical technology, we can prevent a lot of these situations. More atypically we will have a situation with a physician who has been providing care for a family. He doesn't want to lose the family as his patients. He doesn't want to get involved in an enormous bureaucrat snafu of paperwork and reporting. He doesn't know where to go or what to do with the information he has, if he has recognized it as a problem; and he's fearful that he will be sued for getting involved with the situation.

I do a fair amount of educational work with physicians locally and every time I give a lecture we have a crescendo in reporting, so I'm confident that a significant component is a failure of education.

Chairman ROYBAL. First of all, it is not mandatory at the present time for physicians to report.

Dr. PARKINS. We have mandatory reporting in Ohio. We don't have any penalty for failure to report.

Chairman ROYBAL. But we also don't have a mandatory reporting system that's uniform throughout the country.

Dr. PARKINS. Absolutely not.

Chairman ROYBAL. Now, once that report is made by any particular physician, did you say something about the fact that he would be liabel?

Dr. PARKINS. They are concerned that they may be liabel. There is immunity but they—docs are oriented toward making money and staying out of trouble with the law. Okay? There's no money in elder abuse. There's no money to be made in—I hate to be so callous—but there's no money to be made in getting involved in these cases—they are very time-consuming. And they are fearful that the family may sue them, you know, you're saying horrible things about me. A lot of their fears are unholistic. And once they're educated into the issues, they will be more apt to report. We're seeing that locally and nationally. It's an unrealistic fear.

Chairman ROYBAL. That is the most blunt statement that I have heard any physician make since I've been in Congress.

Dr. PARKINS. I'm in trouble now, huh?

Chairman ROYBAL. And it is quite true. But I still want to delve further into the physician's responsibility. Now, in your opinion, do those physicians find that the person that is abusing is suffering from a psychological problem of some kind?

Dr. PARKINS. Yes.

Chairman ROYBAL. Isn't that reportable?

Dr. **Parkins**. In Ohio we have a statute for abuse, neglect, and exploitation—and, you know, have the physical things with the slashings and burning. And then we have the sort of amorphous neglect component, which includes a failure to supply a sort of emotional support, and that kind of thing.

Chairman **Roybal**. But if a person who is found to have some psychological problem has with that particular problem a tendency to become abusive or violent, isn't that situation one that is reportable at the present time?

Dr. **Parkins**. It is reportable, yes.

Chairman **Roybal**. Is that reportable in all States the same?

Dr. **Parkins**. No.

In defense of docs, one of the frustrations is you can identify a problem but there's nowhere to go with it.

I did a presentation for a senior center, and after my presentation—you know, basically trying to tell the old people how to prevent themselves from becoming dependent, because 1 in 10 dependent becomes victims of abuse. Afterward, the senior center director came to me and said, I have a couple of people here who I am convinced are being abused. We've called the police; we've called the Adult Protective Services; we don't know what to do because they keep telling us they're too busy to respond.

Chairman **Roybal**. Dr. Tatara, you stated in your report that the national estimate from the Council of Domestic Elder Abuse was in 1986, that there were 117,000 reports. In 1987, there were 128,000, and in 1988, 140,000. But then you also said that in those same years—for example, in 1986 it is estimated that there were 1.6 million cases of abuse that were not reported. And then it increases to 1.8 million in 1987 and 2 million in 1988.

Now, I ask you this question: does that indicate that we need in this country a mandatory reporting system?

Dr. **Tatara**. Mr. Chairman, I would like to answer your question in two parts. First, this is not a precise science in terms of estimating a national estimate. But it is clear that when we look at data that we have collected and data that are available elsewhere, there has been a steady increase in reported cases.

So reports are being made increasingly. I am not saying at least that the incidence itself is in fact being increased significantly. However, we know that when we see fires reported, then there are increased incidences of fires in town.

Now, in terms of whether we need a mandatory reporting system at the State or not, I cannot answer that question. However, unless, I can tell you, cases are brought to the fore, no services can be provided. Although there is no guarantee that a State having a mandatory system can better protect its citizens and elders; however, based upon what we have observed, those States which have been successfully implementing a mandatory reporting system have identified more cases of elder abuse.

Chairman **Roybal**. Then the answer seems to be that in those States that have had mandatory reporting, you do much better in prosecution or in remedying the situation. So a mandatory reporting system may be one thing that this committee can consider as a possible recommendation.

Before we adjourn, because we're going to try to adjourn as soon as we can, I'm going to ask for volunteers—that is, from the panel—to answer this one question:

If you had only one recommendation to make to this committee, what would that recommendation be?

Think about it while we recognize Mr. Wyden for his round of questioning and then we will come back to the panel for answers to that question: what one recommendation do you have to make to this committee?

Mr. Wyden?

Mr. **Wyden**. Thank you very much, Mr. Chairman. I appreciate your graciousness for this second round.

Let me ask all of you who are advocates, isn't it a fact that if the States are more aggressive in terms of their reporting—and I strongly support Chairman Roybal's position in terms of encouraging more reporting and more uniform reporting—that when we get more reporting the States don't have the funds for the protective services; isn't that correct?

Mr. Harshbarger?

Mr. **Harshbarger**. Yes.

Mr. **Wyden**. Do any panelists disagree with that?

Mr. **Harshbarger**. But, at least we would be able to focus attention and raise the public conscious in a way that we never would without the legislation. We can deny it and pretend the problem isn't there, and then we don't have to have the services, but that is not constructive or cost effective.

I'll get the case at the end of the line; victims like Mr. Jones will pay the price for that. We'll have murder; we'll have more people dying of neglect. Dr. Sue Parkins will see them. We can do that; that's the way we've handled it to date, but there would be far too many needless and preventable casualties.

Mr. **Wyden**. The reason I asked the question is that I think as a result of Federal budget cuts we've put the States in sort of a Catch-22; if we want them to be aggressive—and we all do, for the reasons we've been talking about—they then don't have the funds for protective services.

We talk about child abuse—the States are doing more in the area of child abuse for one specific reason: and that is the Federal Government gives them cash to do it. The Federal Government has not given the States the aid to do it.

And any way you slice it, after the reporting that we want to see is done—and Chairman Roybal's suggestion for uniform reporting—we have got to follow up. I think if we don't, we will not have addressed this in the comprehensive way you advocate.

Just a couple of other questions. One that I've not heard addressed, Dr. Parkins. Is there evidence that when people are abused that there is a lack of adequate places for them to go?

One of the recommendations in the report is that some sort of temporary shelter program be established for those who are elderly who have been abused. And I'm curious, have you found in your work that there really are a lack of safe places for older people who have been abused to go?

Dr. **Parkins**. Yes, unequivocally. We have a lack of safe havens for the individuals. It's a complicated problem because a lot of these people have health care needs and they can't go into a—I know we have a battered women's shelter that the elderly women can go into, but a lot of them have health care needs that can't be met in the battered women's shelter.

More frustrating—I think something that probably has contributed to the physician's lack of reporting and lack of being aggressive on the issue is we can't get any help for them in the home. A lot of the caregivers truly would like to be good caregivers. They're not educated, they didn't go to medical school or nursing school. They don't know what to do to prevent bedsores. A lot of doctors don't know what to do to prevent bedsores. And they can't get funding to pay for the devices. We can't get a nurse in there. We can't give them day care.

A lot of these people, if they could simply have mom or dad in a protected environment for a few hours during the day so that they could take care of their own needs, wouldn't become abusers. No, there's no place for these people, and they are a fearful population. They don't want to come forward because they are afraid they will be stuck in the proverbial old folks home or the government will come in and make them a lot of promises and they will all fall apart.

Mr. **Wyden**. One last question for you, Dr. Parkins.

How frequent is elder abuse of a sexual variety?

Dr. **Parkins**. Again, I am fundamentally founded in science and we do not have any good scientific studies. In my experience, it's probably about 10 percent. But if elder abuse goes undetected, sexual abuse of the elderly is even more common.

I had a situation where a lady came from an extended care facility—she had reported for 3 or 4 days to the nursing staff that she was sexually assaulted, and they didn't believe her. Subsequently, her roommate was having problems with the blood pressure and the nursing staff said, honey, what's wrong? The woman said, well, it's what happened to Sadie the other day.

By the time the lady came to me, she had been cleaned daily by the extended care facility and there was no physical evidence. And, you know, there was absolutely nowhere to go for a prosecutor in that kind of a case. We either don't believe them when they tell us, or in this situation as I was talking to the lady, and I said, how did this man come to leave your room? Did you scream? Did you fight with him?

She said, honey, I'm so confused all the time, half the time I don't know what happened and what I imagined happened. She couldn't give a lot of answers herself.

So, yes, it happens a lot. I don't have a clue how often. Now we do exams before we clean up.

Mr. **Wyden**. I think you all have been very helpful and I am anxious to hear the response to Chairman Roybal's question. But when you listen to the picture that's been painted, you see that older people are uncomfortable about describing the problem: the States don't have the resources to fund the protective services that are needed; the Federal Government passes laws that authorize programs but then won't put dollars into funding them; we're going to have a lot of work to do at every level, from the private sector to the Federal Government.

I think what you have painted is a national shame and it ought to embarrass and anger every Member of Congress until we get a strategy to turn this around.

You all have been excellent.

Thank you for the extra round of questions, Mr. Chairman.

Chairman **Roybal**. Thank you, Mr. Wyden.

I'd like to associate myself with the remarks made by Mr. Wyden with regard to the shocking situation that has been under discussion at this hearing. I think the facts speak for themselves.

One of the things that has been of great interest is the statistics that we find. For an example, in the chart right here to my left, we find a breakdown of elder abuse cases in each State; and we find that the reported cases are just a fraction of those that exist in every State. Of course, those are projections as to the total number of cases. But nevertheless, there is a great difference.

And then we go to the chart here to my right and we find that when it comes to the problem of children, we're doing better statewise; in each State the budget per child exceeds greatly any monies that are spent for the elderly. In the case of child abuse, we had legislation that has made the difference. The question this committee comes up with is: what is the real difference?

We don't know. We're going to look into this subject matter very carefully and come up with what I hope will be a recommendation that will be acceptable to the Congress of the United States.

But the fact is that over a million seniors are being abused in this country each year. It is a shame that we have to continue talking about some of these things, and it's a shame that for the last 10 years we haven't done anything about it. We had this same hearing 10 years ago. Well, it seems to me it's time to move forward.

I will be asking the question I mentioned earlier—I hope you have thought about it. But before we do that I'd like to recognize one of our colleagues, a young lady that has been active in this committee, always interested in the problems of the senior citizen community of the United States, Mrs. Bentley.

Mrs. **Bentley**. Thank you, Mr. Chairman.

Mr. Chairman, I, too, want to associate myself with the remarks of both of you in these last few minutes. And I also ask unanimous consent that the statement of mine be included in the opening of this record today.

Chairman **Roybal**. Without objection, so ordered.

Mrs. **Bentley**. I was wondering, Mr. Chairman, or maybe I should ask our witnesses here today, do any of you know whether we have any statistics regarding elderly abuse in foreign countries, or is anything like that available at all?

Mr. **Harshbarger**. In fact, there is a study that was done by at least one of the professors at the Adult Protective—it's the gentleman from Florida, the University of Florida, at least did a tentative study of foreign countries. I'm sure Toshio can either get that for you or give you some information.

They admit right upfront it's not necessarily scientific, but at least there's some work that's been done. Toshio can speak to that.

Mrs. **Bentley**. Can you give us any indication at all as to how the United States compares with any of these countries that you included in your study?

Dr. TATARA. Mr. Harshbarger referred to Dr. Cosberg—he is one of the forerunners of those of us who have studied this program. He studied many countries problems on elder abuse. However, the study methods are not consistent and I have not seen at all the picture of it, therefore, I am not able to answer that question precisely. However, I would be happy to submit in writing later to the committee.

One study that was conducted by a Dr. Carl Peermore and his colleague is of note; that is a study of the Canadian situation. Whether the study was completed or not, I don't know. But when it's completed, then I'm sure it will be published like their study was published in the Journal of Genetology a couple of years ago and repeated by many experts as a most credible source of prevalence of elder abuse in this country.

Mrs. BENTLEY. Yes, I would appreciate anything you could supply us in writing. I just might add one more comment, Mr. Chairman. What you said about the drastic difference between the abuse and child care cases and elder abuse, and the difference may be as a result of the legislation that has been imposed in regard to children. I think that we need to take those same drastic steps for the elderly, particularly as we see the numbers growing. And the elderly are almost less able and more fearful, actually, of defending themselves than even children today, because they are so frightened and always afraid of being thrown out of a nursing home, or being thrown out of here. They know what tough times are, and I think anything we can do to spur this along will be very important.

Again, Mr. Chairman, congratulations for having this.

Chairman ROYBAL. Thank you, Mrs. Bentley.

Now I'd like to get back to the panel and see how many volunteers we have for a recommendation to the committee. I understand, Mr. Harshbarger, that you are the first one to volunteer; is that correct?

Mr. HARSHBARGER. I can say it in one sentence: I think you ought to pass H.R. 220 because it sets forth a framework in which many of the things that we have discussed can begin, in terms of forming uniformity and consistency.

It will foster a great deal of public/private partnerships, which are very important. And multidisciplinary cooperation alone has helped a great deal.

I think the bill should pass. You've got to have some seed money, you also need some private money; but this bill is the framework that I urge we start with.

Chairman ROYBAL. Thank you very much.

Anyone else have a recommendation to make?

Dr. PARKINS. I would certainly support that. But I think that the key for me is that it needs to be looked at as a framework. We have an enormous problem—we've cut our elderly adrift. Even those of us who identified the problem are hard-pressed to deal with it. We just don't have the health care benefits we need to for our elderly. They have to get in desperate straits before we help them. And I think we're going from the wrong direction.

Our Adult Protective Services workers are extremely overtaxed. We have to start helping before it becomes a terribly expensive problem.

Ms. McLaughlin. I agree with both of my colleagues, certainly; and I think it's important that we not forget that it would be just the beginning. And if we are able to begin some kind of national campaign that there will be tertiary services that we have to be prepared to provide in order to continue and to be effective and have a positive impact on those clients that we would end up knowing about.

Dr. Tatara. Mr. Chairman, along with H.R. 220, there is a provision in the Older Americans Act which was added to the 1987 amendment to the Act, Part G, along with H.R. 220, I suggest that the appropriate committee will look into the appropriateness of this as being a vehicle as well.

Along with this there are guardianship bills that are pending or at various stages in Congress right now, and we suggest that this committee, along with other appropriate committees, will study these bills as well, on guardianship.

Chairman Roybal. Thank you very much.

May I just say for the record that some of the provisions of H.R. 220 have already been authorized. In order to put those into effect we have to appropriate $10 million. One of the reasons that that has not been appropriated is that it has not appeared in the administration's budget, nor has it appeared in the budget that was finally adopted by the Congress.

We hope that this year, due to circumstances that seem to be favorable, we will be able to find money for that specific purpose.

But I agree wholeheartedly with your recommendation, that H.R. 220 must be passed by the House and the Senate and become the law of the land. It is more inclusive than the legislation already authorized.

But when that does in fact pass, we will still have the problem of the appropriation. As you all know, all committees of the Congress are authorizing committees but there's only one committee that appropriates. And if you don't appropriate the money, it doesn't make any difference what you pass. So it has to be appropriated, and the money has to be there in order to bring the bill to fruition. Passing legislation is not enough. We also have to include it in the Appropriations Committee.

I happen to be one of those who sits on that Committee on Appropriations, and I will do everything I possibly can to push this this year, depending, of course, on what our allocation is going to be—that we don't know yet. And we will not know that until sometime in the latter part of May.

I would like to thank the members of the panel for their testimony. It has all been excellent. But thank you again primarily for your recommendation that we pass H.R. 220. I think it's an excellent recommendation and we in this committee wholeheartedly agree with you.

At this time, if there are no objections, I would like to enter the prepared statement of Michael Coonan, Director, Center for Advocacy/Ombudsman Services, Sacramento, California, into the hearing record. Hearing no objections, so ordered.

[The prepared statement of Mr. Coonan follows:]

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TESTIMONY TO THE U. S. CONGRESS,
HOUSE OF REPRESENTATIVES,
COMMITTEE ON AGING
CHAIR, THE HONORABLE EDWARD R. ROYBAL

TESTIMONY PRESENTED BY
MICHAEL F. COOMAN, DIRECTOR
CENTER FOR ADVOCACY/OMBUDSMAN SERVICES
MAY 1, 1990

HEARING ON THE ABUSE OF ELDERLY

The overwhelming majority of Americans are genuinely concerned about and take care of their loved ones. This testimony is not about them. Unfortunately, there are a growing number of people in America who have little or no respect or concern for the health and safety of frail, elderly, or adult dependent people (mentally retarded and mentally disabled). These dependent people are easy prey. Often they are isolated when they become victims of abuse and neglect. The abuse and neglect of elderly and adult dependent people is a terrible tragedy. This tragedy is even more devastating when the abuse is carried out by family members.

To acknowledge the abuse and neglect of elderly and adult dependent people by family members is the first step in understanding the problem. The fact that abuse is inflicted upon frail, elderly, and adult dependent people by family members is incontrovertible. Family violence is a fact of life in America. Children are abused by their parents; wives are abused by their husbands; and, elderly and adult dependent are abused by family members. The scope of this problem is measured by statistics -- by numbers, by percentages -- which are detailed in cold, abstract columns and charts. The reality of abuse is revealed in the pain, in the suffering, in the tears, and in the muffled cries for help that go unanswered.

☑ Senior Ombudsman/Advocacy Project
Long-Term Care Ombudsman

☐ Sacramento County Office of Patients' Rights
Medically Indigent Advocacy
Mental Health Advocacy

☐ Senior Community Ombudsman Project

In Sacramento, California, as both the Long-Term Care Ombudsman and the Sacramento County Mental Health Patients' Rights Advocate, we have investigated hundreds of complaints of abuse of elderly and adult dependent people. Many of these victims are abused by family members.

One of the most chilling examples of elder and adult-dependent abuse was inflicted upon two elderly women with dementia who were the responsibility of a relative. They died a miserable death from starvation. This tragedy, and the responsibility of the agencies involved, was investigated by our office. The following is an excerpt from an editorial in the Sacramento Bee summarizing this abuse:

December 12, 1984

The Death of Two Women

> Two elderly women, locked in a room together for four years by a relative who was collecting their Social Security checks and supposedly caring for them, died of starvation in recent months. A new report by the Sacramento County Office of Patients' Rights lays the blame for those deaths squarely on the doorsteps of the County Welfare Department and the University Medical Center (UMC). The facts are stomach-churning. They provoke outrage at almost everyone -- the case worker, the supervisor, the UMC doctors who played a part in this tragic business.
>
> While Catherine West, 74, and Margaret Bowles, 72, were literally wasting away, 'wallowing in their own excrement', weighing no more than 80 pounds at the time of their death, the County Social Worker responsible for cases, Tom Beeler, was filing reports that everything was in apple pie order. Even though the caretaker, the estranged wife of the Bowles' grandson, took off for Reno in August, leaving Bowles alone and helpless (West had died in May), Beeler did not investigate. Ten months after West starved to death, he noted she was making moderate progress.
>
> Just before West died, both sisters were examined at UMC, yet the ambulance driver's suspicions of neglect were never communicated to the doctors and, despite the woman's appalling condition, the report of the UMC examination did not even hint at abuse.
>
> The caretaker has been charged with murder, but that hardly disposes of the case in which officialdom blundered so badly. Something needs to be done, both to respond to the appalling negligence demonstrated in the case and the assurances that this story won't be repeated. Although County Social Workers in the Adult Protective Services Office have been overworked -- their caseloads increased nearly 50% this year; only recently were four new employees authorized -- there is no

> excuse for Bealer's behavior. The Office of Patients' Rights urges that he be fired. That is the unassailably correct recommendation. The supervisor who let Bealer go almost a year ago without actually visiting West and Bowles should also be disciplined.
>
> Beyond the particulars of this appalling case, the Welfare Department badly needs to straighten its house in order to assure a properly anxious public that supervision means supervision, not fictitious form filling. Emergency room physicians at UCMC and elsewhere in the county, who in recent years have become aware of child abuse symptoms, must now be trained to detect a new, equally reprehensible form of violence -- abuse of the elderly.

The litany of abuse of elderly continues. We also investigated a report of a husband who neglected his frail, elderly wife. Our investigation revealed that his wife, 76, was held in her house by her alcoholic husband despite her urgent need for medical attention. She fell in her home and broke her hip. Her husband refused to transport her to a hospital, call an ambulance, or provide medical care. For a year, she was forced to drag her body from her bed across the floor when she needed to use the bathroom; frequently she was not able to manage the trip. When she was finally found -- a year after she broke her hip, she was near death. She had sustained rat bites to her leg, which had become infected. She was delirious, semi-conscious, with a high fever. Her leg had become gangrenous. She was covered with cockroaches and other insects. While in the hospital, her gangrenous leg was amputated. Through the intervention of our office, Sacramento County assumed conservatorship and arranged for her care beyond the control of her husband.

We also investigated the tragedy of a middle-aged adult dependent person (mentally disabled), who suffered severe and irreversible neglect. A description of this abuse was reported in the Sacramento Union on September 15, 1984. It states:

Cops Seek Two in Brothers Alleged Starving

> Arrest warrants were issued Friday for a sister and brother who had allegedly confined their older brother and starved him from 170 pounds to 82 pounds before he was hospitalized in May. Margaret E. Morales, 36, and her brother, Robert Morales, 46, were charged in the warrant with endangering the health and safety of a dependent adult and infliction of great bodily harm against their brother, Alfred Morales, 48.
>
> ... The plight of Alfred Morales, now hospitalized in an Extended Care Program in Yolo Hospital, became known on May 10. He was brought to the emergency room of Methodist Hospital in the back of a station wagon, stuck with his own pus and urine to a mattress.

> 'He looked like somebody who just got out of Auschwitz,' said Michael Coonan, Sacramento County Patients' Rights Advocate.
>
> An emergency room physician described Morales at the time as 'terminal and near fatal' condition. He had almost no blood pressure, no body fluids, bedsores of 3" in diameter, with arms and legs flexed and contracted from lack of use. Authorities said the latter are considered permanent injuries. The hospital personnel became so alarmed at Morales' appearance that they called the police.
>
> Prosecutor Susan Aguilar, who worked on the case, said that one of two responding officers taking pictures of Morales became physically ill when they saw the man's body.
>
> 'My first reaction to the photographs was that they reminded me of pictures taken during the liberation of a concentration camp after World War II,' Aguilar wrote in a letter to Coonan on June 11, shortly after her office undertook the Morales case.
>
> Coonan's office brought the case to the attention of the District Attorney's Office, which filed Friday's warrants under the new state law that took effect in January and made it a felony to endanger the health and safety of a dependent person.

The abuse of elderly and adult dependent people by family members continues. The proposed legislation by the House Committee on Aging is a very powerful first step to begin identifying elderly people who are subjected to abuse. Mandated reporting of abuse in all states is vital. This reporting exposes the terrible tragedies inflicted upon elderly. Following the reports, the investigation and emergency response to complaints of abuse are critical. The proposed funding by the House Committee on Aging for $10 million for investigating is a start. However, we conservatively estimate that the actual cost for intervention on behalf of elder and adult dependent abuse victims by way of emergency response is closer to $150 million annually.

We believe the most important feature in the Committee's proposed legislation is the delegation of the authority from the federal level to the state level for designating the agency responsible for investigating elder and adult dependent abuse. At the state level, it is our responsibility to ensure that further delegation for selecting the investigative agency be vested to the county. At the county level, the governing board (Board of Supervisors) can select the most appropriate and independent agency to investigate complaints of elder and adult dependent abuse.

Currently in California, Adult Protective Services, within the Department of Social Services, is charged with the responsibility for investigating elder and adult dependent abuse in the community.

However, we believe agencies responsible for investigating complaints of elder and adult dependent abuse must be independent of other agencies, particularly those that provide support services. Our investigations have documented many examples of public and private agencies that are responsible for providing services to protect elderly and adult dependent people but failed to carry out their duty. Giving such an agency (Adult Protective Services) the responsibility for investigating elder and adult dependent abuse would force them to, on occasion, investigate themselves. This is analogous to the fox guarding the chickens. This arrangement is a serious mistake. For example, it would be no different than requiring the Long-Term Care Ombudsman (investigator of complaints in Nursing Homes) to be selected by the Nursing Home Administrator. In this situation, the Ombudsman would become a toothless eunuch.

What we have found is that when the responsibility for investigating elder and adult dependent abuse is placed within an agency that provides other support services, it is unlikely that their problems and/or failures are reported and, more importantly, corrected.

We are urging that eventually Long-Term Care Ombudsman, as authorized by the Older American Act, be responsible for investigating elder and adult dependent abuse in both the community and in Long-Term Care Facilities. The Long-Term Care Ombudsman should be designated and provided the funding to carry out this important responsibility.

MFC:rkv

Submitted by:

Michael F Coonan

Michael F. Coonan, Director
Center for Advocacy/Ombudsman Services

Chairman **Roybal**. So on that note, I adjourn the meeting, again thanking each and every one of you.

Mr. **Harshbarger**. Thank you, sir.

Chairman **Roybal**. Thank you very much.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

APPENDIX I

EXECUTIVE SUMMARY

ELDER ABUSE: A DECADE OF SHAME AND INACTION

It was in 1978, over a decade ago, that the House Select Committee on Aging, then chaired by the late Claude Pepper (D-Fla.), heard testimony regarding abuse of older Americans by family members or others entrusted with their care. At that time, such abuse was commonly referred to as "grannyslamming," "grannybashing," or "elderly abuse." Following these hearings, which were convened in Boston, Massachusetts, the Chairman called upon the Committee to conduct the first national investigation documenting the incidence and nature of a still largely hidden and shameful phenomenon affecting hundreds of thousands of our Nation's most helpless and vulnerable citizens--a phenomenon for which the Chairman came to coin the term "elder abuse." In a landmark report issued in 1981 entitled "Elder Abuse: An Examination of a Hidden Problem," the Aging Committee found that elder abuse is simply "alien to the American ideal." Because elder abuse is such a difficult concept to come to grips with, even abused elderly are reluctant to admit their children or loved ones have assaulted them. For this reason, the abuse of our elderly at the hands of their family until recent times has remained largely a hidden problem.

The 1981 report was an effort to provide definition to the nature and incidence of "elder abuse." How frequently does such abuse occur? How many cases are reported annually? How many go unreported? Who is the likely victim? Who is the likely perpetrator? Are abuse cases isolated in nature or do they occur nationwide? Is such abuse increasing or decreasing? What triggers such abuse? What kinds of elder abuse are we talking about? What can the Federal Government and the States do to identify, treat, and prevent the incidence of elder abuse?

What the Committee found was that elder abuse was far from an isolated and localized problem involving a few frail elderly and their pathological offspring. The problem was a full-scale national one which existed with a frequency few have dared to imagine possible. In fact, abuse of the elderly by their loved ones and caretakers existed with a frequency and rate only slightly less than child abuse. And, as later Committee studies would confirm, there was no question that the problem was increasing dramatically from year to year.

The Committee also found that elder abuse was far less likely to be reported than the abuse of children. While 1 out of 3 child abuse cases was reported in 1980, only 1 out of 6 cases of adult abuse came to the attention of authorities. Lastly, the Committee concluded that some 4 percent of the Nation's elderly might be the victims of some sort of abuse, from moderate to severe. In other words, 1 out of every 25 older Americans, or roughly 1 million elderly, were found to be victimized annually.

The findings of this 1981 report led to the Committee's recommendation that the Congress should assist the States in designating agencies at the State level to receive complaints of elder abuse and to identify and treat the victims of this type of crime. In reviewing the history of domestic violence in America, the Committee found that such legislation paid handsome dividends in the area of child abuse prevention and treatment. It seemed obvious that the Federal Government could play a similar role in the analogous area of elder abuse.

Therefore, in order to help the States and stimulate them to improve their own statutes and the protections they offer the infirm and dependent elderly, the Committee recommended the passage of legislation identical to the Child Abuse Prevention and Treatment Act of 1974 as an important step in controlling unwarranted violence against the aged. Subsequently, legislation was introduced in the Ninety-Seventh Congress (H.R. 7551) and every Congress since has sought to carry forth this recommendation. Encouraged by the possibility of financial assistance, the States began modifying their elder abuse-related laws and procedures to gain compliance with the anticipated new law's mandate, which included mandatory reporting provisions. Today, 42 States and the District of Columbia have adopted mandatory reporting provisions as part of their adult protective service statutes. Between 1980 and 1990 alone, 26 States and the District of Columbia enacted mandatory reporting provisions. Prior to 1980, only 16 States had adult protective service laws with such provisions.

In spite of impressive regulatory reform at the State level, the Subcommittee on Health and Long-Term Care, which inherited this issue when Claude Pepper abdicated the Chair of the Aging Committee, but remained Subcommittee Chairman, was disturbed by persistent Congressional delay in the enactment of legislation to assist the States identify, treat and prevent the increasing incidence of elder abuse. In fact, while the Congress approved legislation amending the Older Americans Act in 1987 to funnel funds through the State Agencies on Aging to begin identifying and preventing abuse of older Americans, the funds have yet to be appropriated.

In 1989, nearly a decade after the Congress first convened hearings on the issue of elder abuse, the Subcommittee, now at the direction of its new Chairman, Edward R. Roybal, initiated this inquiry to update what is known about the problem, its prevalence and the adequacy of Federal and State efforts to respond to it.

In order to determine the Nation's effectiveness in coming to grips with this national tragedy, the Subcommittee undertook the following steps:

--Collected, reviewed and tabulated letters and case histories received by the Subcommittee and the Committee over the last 12 years, as well as letters received in response to national news stories documenting the Committee's work in this area.

--Prepared and sent a questionnaire to all State Human Services Departments at the Chairman's request. The responses to these questions were tabulated and appear in Section III of this report. The questionnaire can be found in Appendix I.

--Prepared and disseminated a questionnaire to approximately 100 adult protective service workers in attendance at a national conference on social work in San Francisco in the fall of 1989. The responses to these questions were tabulated and appear later in this report. The questionnaire can be found in Appendix II.

--Reviewed all hearings and reports by Congressional Committees and administrative agencies on abuse of the elderly.

--Conducted follow-up telephone interviews with over one half of the State Human Services Departments. A Directory of Offices Responsible for Adult Protective Services appears in Appendix III.

--Reviewed all books, periodicals, and newspaper references relating to elder abuse and family violence in the possession of the Library of Congress.

--Reviewed and summarized case histories of abuse forwarded to the Subcommittee by the States and concerned citizens. These summaries can be found in Section I of this report.

--Communicated with numerous organizations and service providers representing the elderly to ascertain their views on the problems of elder abuse.

The Subcommittee was able to reach a number of conclusions. They are as follows:

--The Subcommittee found that abuse of the elderly is increasing nationally. About 5 percent of the Nation's elderly may be victims of abuse from moderate to severe. To put this another way, about 1 out of every 20 older Americans, or more than 1.5 million persons, may be victims of such abuse each year. This represents an increase of 1 percent of the elderly population, or 500,000 abuse cases annually since 1980.

--The Subcommittee learned that elderly abuse is far less likely to be reported than child abuse. While 1 out of 3 child abuse cases is reported, only 1 out of every 8 cases of elder abuse is reported. This represents a significant increase from the Subcommittee's 1980 estimate of 1 in 5 cases.

--The Subcommittee found that the majority of States--four-fifths or 43 States (including the District of Columbia)--have enacted State statutes or adult protective service laws to provide for mandatory reporting of elder abuse. This represents a substantial increase over 1980, when only 16 States had such statutes in place, and in 1984 when 38 States (including the District of Columbia) had enacted such provisions. The Subcommittee found that State implementation and enforcement of these laws is predicated on the passage of legislation providing financial incentives to the States analogous to child abuse funding. As such legislation has not yet been approved, most States are hard-pressed to carry out these mandates. While it is a shame that the States were only able to spend about $45.03 per child resident for protective services in 1989, it is a crime that they spent only $3.80 for each elderly resident in 1989. While the average amount per elderly resident for protective services has increased from $1.52 to $3.80 over the last 10 years, much of that has been eaten away by 62 percent increase in prices due to inflation over the same period.

--The Subcommittee found that absent the passage of legislation providing assistance to the States in this area, the States are severely hampered in channeling monies into this newly designated social services area--elder abuse protective services--on their own authority. In fact, some States such as Louisiana have simply stopped providing elder abuse protective services. Since 1980, the primary source of Federal funding for State protective services, the Social Services Block Grant, has been cut nearly one-third by direct cuts and inflation. Faced with the clear need to do more, the Federal Government is doing considerably less.

Section I of this report makes for unpleasant reading. It presents summaries of examples of abuse from every part of the United States. In response to the aforementioned survey of the States and Adult Protective Service workers, the Subcommittee received thousands of accounts of abuse ranging from systematic theft of a Social Security check to violent physical abuse, including rape and murder. Also summarized are case histories brought to the Subcommittee's attention over the last 10 years by concerned individuals and abused elders themselves. Lastly, local newspaper accounts culled by the Subcommittee over the decade provided the Subcommittee with hundreds of examples of elder abuse which typify situations they encounter on a daily basis.

Physical violence, including negligence, and financial abuse appear to remain the most common forms of abuse, followed by abrogation of basic constitutional rights and psychological abuse. Most instances of elder abuse are recurring events rather than a single incident. All of the abuse cases have a number of elements in common. for example, it is possible to draw a profile of the most likely victims of elder abuse and those most likely to perpetrate it.

The victims of elder abuse are likely to be old, age 75 or older. Women are more likely to be abused than men. This is in part due to their life expectancy. Women live longer, on the average, than men. The victims are generally in a position of dependency, that is, they are relying on others, be it their family or an unrelated caregiver for care and protection.

A profile of the elder abuser also emerges. The likely abuser will usually be experiencing great stress. Alcoholism, drug addiction, marital problems and long-term financial difficulties all play a role in bringing a person to abuse his or her parents. The son of the victim is the most likely abuser, followed by the daughter of the victim. It is interesting to note that the abuser, in many cases, was abused by the parents as a child.

The Subcommittee also found that the abused elder is less likely to report the incident of abuse than abused persons in other age groups. It is apparent that they are often ashamed to admit their children or loved ones abuse them or they may fear reprisals if they complain. Interestingly, since the release of the Committee's 1981 report on elder abuse, the percentage of cases of elder abuse that go unreported has increased. Prior to 1981, only about 1 in 6 cases of elder abuse was reported. Today, about 1 in 8 cases comes to the attention of protective services.

Section II of this report recalls the theories for the cause of elder abuse as documented in the earlier Committee report. In sum, there is no single explanation for why elders are abused. Rather, any one or a combination of factors detailed in this section may explain why elders are abused. The abuser may lack community resources to assist him or her in their caregiving role; if mistreated as a child, the abuser may view abuse of the parents as a means of retaliation or revenge; sometimes, after parent and child have been separated emotionally or geographically for lengthy periods, the elderly parent's return is viewed as an intrusion; for certain families, violence is the normative response to stress and is a tradition carried from generation to generation; many middle-aged family members, finally ready to enjoy time to themselves, are resentful of a frail, dependent elderly parent; increased life expectancy is another factor leading to increased incidence of elder abuse--the dependency period of old age has been extended; and there are certain environmental conditions which can precipitate stress, which may then lead to abusive or neglectful behavior--quality of housing, unemployment, alcohol and drug abuse, and crowded living conditions can by themselves or in combination with other factors encourage mistreatment of a dependent elderly person.

Section III of this describes data received from the States and Adult Protective Service workers and supports the following conclusions:

--43 States (including the District of Columbia) have what they consider to be adult protective service laws which require mandatory reporting, but these vary widely in scope. (There is, however, little consistency among these States as to who is required to report and what penalties will apply when there is a failure to do so.)

--The percentage of States' total protective services budgets allocated to elderly protective services has remained disproportionately low. While the incidence of elder abuse is increasing annually, the percent of State budgets for adult protective services have declined from 6.6 percent in 1980, to only 4.7 percent in 1985, and to less than 4.0 in 1989.

--On average, each State in 1989 spent about $3.80 per elderly resident for protective services. The picture is a bit brighter for child abuse victims, for whom the States, on the average, spend about $45. Nearly one fourth (10 of 42) of States reporting spent less than a dollar per elderly resident for these services in 1989.

--Some 70 percent of all adult abuse cases reported annually involve elderly victims. This represents a 10 percent increase over 1980, when only about 60 percent of adult abuse cases involved the elderly. The States indicated, however, that only 1 in about 8 cases of elderly abuse is ever reported. This is down from 1 in 5 in 1985.

--According to the States, about 5 percent of the Nation's elderly may be the victims of some form of abuse, physical, financial, or emotional, each year. To put this another way, about 1,500,000 older Americans are abused by family, loved ones and caregivers each year. This represents an increase of over 500,000 elder abuse cases annually since 1980.

--The vast majority of the States, 90 percent, told the Subcommittee that the incidence of elder abuse was increasing. Six States told the Subcommittee that the incidence of elder abuse is not only increasing, but is increasing at a rapid rate.

--The majority of elder abusers are relatives of the victims, often a son or daughter with whom the elderly individual resides. The States indicated that, on average, only 25 percent of abusers are caretakers unrelated to the elderly victims. Thus, nationally, up to 3 of 4 elder abusers are family members.

--The overwhelming majority of States, over 95 percent, reported widespread support for grants to the States for the prevention and treatment of elder abuse in the same manner in which the States are assisted to curb child abuse. Also, the States voiced nearly unanimous approval for the establishment of long-term health care programs, emergency shelters for abused adults, and a national clearinghouse and toll-free hotline for the disbursement nationally of information and abuse reports.

--The overwhelming majority, over 90 percent, of adult protective service workers surveyed reported support for the establishment of a Federal program of assistance to the States to address elder abuse in the same manner that they respond to child abuse.

Section IV discusses Congressional and Federal action with respect to elder abuse over the last decade in the United States, and Section V includes a number of policy options for the consideration of the Congress and the States:

--There needs to be a coordinated national effort to confront the issue of elder abuse and the Federal Government should assist the States in their efforts to deal with this pervasive problem. The Congress should consider passage of H.R. 220, legislation analogous to the Child Abuse Prevention, Identification and Treatment Act of 1974 which would provide Federal funds to States which had mandatory reporting laws and provided for immunity from prosecution for persons reporting incidences of abuse, neglect and exploitation. In addition, it should provide for the establishment of a National Clearinghouse on Elder Abuse and a toll-free hotline for collection reports of abuse and disseminating information to interested parties.

--Since 1981, the primary source of Federal funding for protective services, the Social Services Block Grant, has been cut in real terms nearly one-third by direct cuts and inflation. Also, important amendments to the Older Americans Act Amendments of 1987 providing for a program of elder abuse identification and prevention as well as increased authorities for Ombudsmen in this area were authorized but never fully appropriated. Congress should consider appropriating the fully authorized levels of these important programs.

--Experts agree that the provision of assistance to those who care in the home for dependent and chronically ill family members is essential in preventing or reducing the incidence of abusive situations. Congress should adopt legislation, such as H.R. 2263, "The Long-Term Home Care Act," to provide long-term care services in the home to chronically ill elderly, disabled and children.

--The States should consider enacting mandatory reporting legislation and otherwise upgrading their statutes to provide specific protections to elderly equal to those provide to children.

--The Congress should authorize the State Medicaid Fraud Control Units to investigate and prosecute all resident abuse and neglect complaints involving violations of State criminal laws for residents of nursing homes and board and care homes.

--The Legal Services Corporation should provide legal assistance to abused elders.

TABLE 1—Does Your State Have an Office Responsible for Handling Cases of Elder Abuse?

State	Yes	No
Alabama	X	
Alaska	X	
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho	X	
Illinois[1]		
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana		X
Maine	X	
Maryland	X	
Massachusetts	X	
Michigan	X	
Minnesota	X	
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska[1]		
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina[1]		
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming	X	
District of Columbia	X	
Puerto Rico	X	
Total	48	1

[1] Did not respond to survey.

TABLE 2—1989 State Budgets for Protective Services

State	Total budget	Elderly protective services budget	Child protective services budget
Alabama	$43,452,474	N/A	$32,267,502
Alaska	31,497,100	[4]$1,864,992	28,523,900
Arizona	33,633,425	96,156	31,344,000
Arkansas	N/A	203,000	30,900,000
California	456,300,000	[4]7,920,000	443,100,000
Colorado	39,092,208	986,324	37,298,819
Connecticut	N/A	N/A	N/A
Delaware	8,808,828	306,446	8,430,000
Florida	46,833,832	[4]7,679,474	36,594,534
Georgia	28,900,000	7,102,000	21,100,000
Hawaii	12,943,316	183,266	12,760,050
Idaho	6,946,984	322,632	5,938,459
Illinois[6]			
Indiana	N/A	N/A	N/A
Iowa	7,547,761	239,394	[5]8,822,325
Kansas	[1]1,180,370	[4]0	[1]1,180,370
Kentucky	35,961,646	2,327,405	26,423,100
Louisiana	107,000,000	0	[3]107,000,000
Maine	41,076,000	2,400,000	38,076,000
Maryland	32,600,000	1,740,000	25,100,000
Massachusetts	308,300,000	2,000,000	306,300,000
Michigan	355,200,000	2,892,800	350,800,000
Minnesota	N/A	N/A	N/A
Mississippi	6,061,886	189,099	5,883,689
Missouri	62,893,131	1,080,843	61,047,750
Montana	18,083,000	2,286,160	15,315,000
Nebraska[6]			
Nevada	N/A	N/A	73,670
New Hampshire	N/A	49,219	N/A
New Jersey	142,300,000	1,656,000	[3]140,000,000
New Mexico	8,432,700	1,266,400	7,632,200
New York	182,700,000	20,349,000	150,400,000
North Carolina[6]			
North Dakota	[3]1,075,000	60,000	[3]1,000,000
Ohio	23,042,009	4,814,549	17,032,872
Oklahoma	11,013,116	1,355,841	9,049,200
Oregon	14,046,369	941,732	13,000,000
Pennsylvania	[3]23,700,000	4,000,000	19,700,000
Rhode Island	N/A	N/A	N/A
South Carolina	9,568,569	1,069,011	7,786,884
South Dakota	5,649,370	105,180	5,433,134
Tennessee	34,432,433	1,766,061	29,080,733
Texas	165,460,541	[4]7,488,000	154,762,515
Utah	4,631,225	110,000	4,411,225
Vermont	2,924,815	217,000	2,707,775
Virginia	[3]23,936,039	3,934,766	[3]18,669,685
Washington	11,969,975	465,588	11,000,000
West Virginia	4,875,000	555,000	3,950,000
Wisconsin	N/A	N/A	N/A
Wyoming	8,175,000	157,500	8,000,000
District of Columbia	45,700,000	780,000	44,900,000
Puerto Rico	12,822,409	961,749	11,365,213
Average	58,089,000	2,295,000	53,298,400

[1] Protective services included in other services' budgets.
[2] Does not include State administrative costs.
[3] Estimate.
[4] Subcommittee estimate based on percentage of caseload elderly.
[5] Only Title XX funds for staff.
[6] Did not respond to survey.

TABLE 3—1989 State Budgets for Child and Elderly Protective Services: Per Child and Elderly Resident

State	Budget	Budget
	Per child	Per elderly
Alabama	$22.94	N/A
Alaska	170.80	[2]$83.24
Arizona	32.92	0.22
Arkansas	47.01	0.58
California	58.13	[2]2.03
Colorado	42.92	3.15
Connecticut	N/A	N/A
Delaware	50.78	3.98
Florida	13.09	[2]3.49
Georgia	11.88	11.15
Hawaii	44.46	1.81
Idaho	19.53	2.73
Illinois[3]		
Indiana	N/A	N/A
Iowa	8.55	[2]0.57
Kansas	1.81	[1]0
Kentucky	28.93	5.30
Louisiana	82.56	0
Maine	125.25	14.91
Maryland	21.88	3.49
Massachusetts	229.95	2.48
Michigan	278.07	2.50
Minnesota	N/A	N/A
Mississippi	7.29	0.59
Missouri	46.53	2.34
Montana	68.30	22.19
Nebraska[3]		
Nevada	0.28	N/A
New Hampshire	N/A	4.09
New Jersey	78.46	1.84
New Mexico	17.00	8.17
New York	34.53	8.74
North Carolina[3]		
North Dakota	5.46	0.67
Ohio	6.03	3.51
Oklahoma	10.28	3.21
Oregon	18.95	2.47
Pennsylvania	6.92	0.22
Rhode Island	N/A	N/A
South Carolina	8.20	2.82
South Dakota	27.58	1.05
Tennessee	23.21	2.89
Texas	31.04	[2]4.49
Utah	7.01	0.78
Vermont	19.20	3.29
Virginia	12.71	6.14
Washington	9.24	0.84
West Virginia	8.28	2.07
Wisconsin	N/A	N/A
Wyoming	58.74	3.49
District of Columbia	325.38	10.12
Puerto Rico	N/A	N/A
Average	45.03	3.80

[1] Budget included in other programs.
[2] Subcommittee estimate based on percentage of caseload elderly.
[3] Did not respond to survey.

TABLE 4—Number and Type of State Adult Protective Services Employees

State	Total	Clerical	Professional
Alabama	N/A	N/A	128
Alaska	3.5	0	3.5
Arizona	90	8	82
Arkansas	10	1	9
California	5.5	0.5	5
Colorado	55	0	55
Connecticut	16	7	9
Delaware	12	1	11
Florida	216.5	17	199.5
Georgia	157	N/A	N/A
Hawaii	5	0	5
Idaho	23	3	18
Illinois[b]			
Indiana	3	1	2
Iowa	9	2.5	6.5
Kansas	N/A	N/A	25
Kentucky	104	0	104
Louisiana	0	0	0
Maine	73	7	66
Maryland	81	5	76
Massachusetts	6[a]	1	5
Michigan	55	10	45
Minnesota	N/A	N/A	N/A
Mississippi	N/A		
Missouri	69	6	63
Montana	77	12	65
Nebraska[b]			
Nevada	15	13	2
New Hampshire	55	15	40
New Jersey	5[a]	1	4
New Mexico	47	N/A	N/A
New York	400+	N/A	N/A
North Carolina[b]			
North Dakota	5[a]	0.5	4.5
Ohio	262		215.5
Oklahoma	45.5	8	37.5
Oregon	30.8	7.4	20.1
Pennsylvania	1.5	0.25	1.25
Rhode Island	1	0	1
South Carolina	200	40	160
South Dakota	6.3	0	6.3
Tennessee	68	0	68
Texas	396	99	297
Utah	6	0	6
Vermont	6	1	5
Virginia	100	29	71
Washington	20	0	20
West Virginia	45	5	40
Wisconsin	10[a]	0	10
Wyoming	6	5	1
District of Columbia	29	5	23
Puerto Rico	34	10	24
Average	63.8	7.8	46.3

[a] State employees only—unspecified number of local staff.
[b] Did not respond to survey.

TABLE 5—State Budgets for All Protective Services: 1980–89

State	1980	1984	1989
Alabama	$14,558,889	$19,259,072	$43,452,474
Alaska	15,541,000	13,308,200	31,487,100
Arizona	4,764,818	1,300,000	33,633,425
Arkansas	1,808,000	N/A	N/A
California	129,124,251	273,200,000	456,300,000
Colorado	13,333,978	19,000,000	39,082,208
Connecticut	N/A	457,000	N/A
Delaware	N/A	N/A	8,808,828
Florida	18,551,108	35,310,537	48,833,832
Georgia	10,125,011	46,808,486	28,900,000
Hawaii	2,139,800	2,900,000	12,943,316
Idaho	3,291,543	5,782,300	6,946,884
Illinois	N/A	67,209,700	[a]
Indiana	15,524,000	N/A	N/A
Iowa	7,303,318	3,214,000	7,547,781
Kansas	N/A	0	[b]1,180,800
Kentucky	5,989,704	18,841,305	35,981,846
Louisiana	8,414,349	8,588,154	107,000,000
Maine	2,867,481	4,909,000	41,078,000
Maryland	9,105,039	N/A	32,800,000
Massachusetts	N/A	N/A	308,300,000
Michigan	16,822,037	16,800,000	355,200,000
Minnesota	28,282,000	18,980,000	N/A
Mississippi	N/A	3,970,158	8,081,888
Missouri	N/A	31,350,000	62,[illegible]93,131
Montana	1,284,279	11,534,000	18,080,000
Nebraska	2,453,945	2,875,000	[a]
Nevada	N/A	5,731,720	N/A
New Hampshire	N/A	N/A	N/A
New Jersey	11,075,664	101,400,000	142,300,000
New Mexico	1,902,031	N/A	8,432,700
New York	52,796,798	88,400,000	182,700,000
North Carolina	3,400,721	10,731,226	[a]
North Dakota	N/A	N/A	[d]1,075,000
Ohio	23,000,000	28,077,323	23,042,000
Oklahoma	11,000,000	7,371,311	11,013,116
Oregon	N/A	N/A	14,046,389
Pennsylvania	16,841,352	N/A	[c]23,700,000
Rhode Island	N/A	N/A	N/A
South Carolina	6,462,378	9,003,768	9,568,589
South Dakota	1,335,579	4,341,000	5,848,370
Tennessee	9,540,966	18,300,000	34,432,433
Texas	48,230,190	98,741,802	165,460,541
Utah	835,104	868,000	4,831,225
Vermont	N/A	11,109,897	2,924,815
Virginia	9,472,242	15,323,076	[c]23,938,039
Washington	4,801,057	8,127,133	11,989,975
West Virginia	3,943,158	6,845,500	4,875,000
Wisconsin	N/A	N/A	N/A
Wyoming	1,755,124	7,000,000	8,175,000
District of Columbia	2,408,700	N/A	45,700,000
Puerto Rico	N/A	N/A	12,822,400
Average	14,051,230	26,934,868	58,477,859

[a] Protective services included in other services' budgets.

[b] Does not include State administrative costs.

[c] Estimate.

[d] Only Title XX funds for staff.

[e] Did not respond to survey.

TABLE 6—State Budgets for Elderly Protective Services Per Elderly Resident: 1980–89

State	1980	1984	1989
Alabama	$2.09	$4.22	N/A
Alaska	40.67	N/A	[2]$83.24
Arizona	2.41	8.12	0.22
Arkansas	0.21	N/A	0.58
California	N/A	N/A	[2]2.83
Colorado	2.75	7.22	3.15
Connecticut	N/A	N/A	N/A
Delaware	N/A	0.85	3.98
Florida	0.82	1.05	[2]3.40
Georgia	1.02	3.73	11.15
Hawaii	N/A	1.12	1.81
Idaho	0.54	12.71	2.73
Illinois	N/A	0.20	[3]
Indiana	N/A	N/A	N/A
Iowa	0.55	0	[2]0.57
Kansas	N/A	0	[2]0
Kentucky	2.15	3.24	5.03
Louisiana	N/A	0.56	0
Maine	0.09	4.60	14.91
Maryland	1.21	N/A	3.49
Massachusetts	1.65	N/A	2.48
Michigan	0.72	0.75	2.50
Minnesota	4.65	4.33	N/A
Mississippi	N/A	0.53	[2]0.59
Missouri	N/A	8.21	2.34
Montana	0.87	7.63	22.19
Nebraska	1.62	1.05	[3]
Nevada	N/A	1.91	N/A
New Hampshire	N/A	3.29	4.09
New Jersey	1.58	2.27	1.64
New Mexico	1.46	N/A	8.17
New York	2.35	3.96	8.74
North Carolina	0.44	2.44	[3]
North Dakota	N/A	N/A	0.67
Ohio	0.14	2.35	3.51
Oklahoma	1.15	N/A	3.21
Oregon	N/A	N/A	2.47
Pennsylvania	N/A	0.86	0.22
Rhode Island	N/A	0.78	N/A
South Carolina	2.03	2.80	2.82
South Dakota	0.14	5.81	1.05
Tennessee	2.27	4.15	2.89
Texas	0.12	1.55	[2]4.49
Utah	0.05	0.11	0.78
Vermont	N/A	1.08	3.29
Virginia	2.04	3.75	8.14
Washington	N/A	0.55	0.84
West Virginia	1.45	1.19	2.07
Wisconsin	N/A	N/A	N/A
Wyoming	5.34	2.70	3.49
District of Columbia	1.95	N/A	10.12
Puerto Rico	N/A	N/A	N/A
Average	1.52	2.81	3.80

[1] Budget included in other programs.
[2] Subcommittee estimate based on percentage of caseload elderly.
[3] Did not respond to survey.

TABLE 7—Percentage of Adult Abuse Cases Involving Elderly Victims

State	1988
Alabama	N/A
Alaska	58
Arizona	65.5
Arkansas	65
California	60
Colorado	57
Connecticut	100
Delaware	75
Florida	75
Georgia	67
Hawaii	92
Idaho	65
Illinois[b]	
Indiana	82
Iowa	66
Kansas	56
Kentucky	28
Louisiana	75
Maine	78
Maryland	60
Massachusetts	100
Michigan	60
Minnesota	N/A
Mississippi	50
Missouri	65
Montana	73
Nebraska[b]	
Nevada	87
New Hampshire	71
New Jersey	72
New Mexico	70
New York	60
North Carolina[b]	
North Dakota	65
Ohio	87
Oklahoma	84
Oregon	88
Pennsylvania	N/A
Rhode Island	60
South Carolina	66
South Dakota	41
Tennessee	70
Texas	70
Utah	52
Vermont	62
Virginia	74
Washington	48
West Virginia	N/A
Wisconsin	88
Wyoming	90
District of Columbia	78
Puerto Rico	60[a]
Average Percentage	69.2

[a] 1987 Figure, 1988 Unavailable

[b] Did not respond to survey.

TABLE 8—Do a Significant Number of Elder Abuse Cases Go Unreported?

State	Yes	No
Alabama	X	
Alaska	X	
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho	X	
Illinois[a]		
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	
Massachusetts	X	
Michigan	X	
Minnesota	N/A	
Mississippi	N/A	
Missouri	X	
Montana	X	
Nebraska[a]		
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina[a]		
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming	X	
District of Columbia	X	
Puerto Rico	X	
Total	47	0

[a] Did not respond to survey.

TABLE 9—What Is the Ratio of Reported Cases to Unreported Cases?

State	1988
Alabama	N/A
Alaska	N/A
Arizona	1/10
Arkansas	N/A
California	1/10
Colorado	1/5
Connecticut	1/10
Delaware	1/2
Florida	1/4
Georgia	N/A
Hawaii	N/A
Idaho	N/A
Illinois[1]	
Indiana	1/50
Iowa	1/2
Kansas	1/5
Kentucky	N/A
Louisiana	N/A
Maine	1/33
Maryland	1/2
Massachusetts	1/10
Michigan	1/4
Minnesota	N/A
Mississippi	N/A
Missouri	1/7
Montana	1/30
Nebraska[1]	
Nevada	N/A
New Hampshire	1/1
New Jersey	1/3
New Mexico	N/A
New York	N/A
North Carolina[1]	
North Dakota	1/1
Ohio	1/12
Oklahoma	1/10
Oregon	N/A
Pennsylvania	N/A
Rhode Island	N/A
South Carolina	1/5
South Dakota	N/A
Tennessee	1/13
Texas	1/8
Utah	1/2
Vermont	1/5
Virginia	1/5
Washington	1/3
West Virginia	1/5
Wisconsin	1/16
Wyoming	1/5
District of Columbia	N/A
Puerto Rico	N/A
Average	1/7.8

[1] Did not respond to survey.

TABLE 10—Number of Elder Abuse Cases In Each State—1988

State	Reported cases	Total cases[1]
Alabama	4,931	[2]38,462
Alaska	273	[2]2,129
Arizona	5,067	50,670
Arkansas	1,040	[2]8,112
California	18,602	186,020
Colorado	2,395	11,975
Connecticut	3,858	38,580
Delaware	441	882
Florida	14,835	59,340
Georgia	7,035	[2]54,873
Hawaii	343	[2]2,675
Idaho	1,042	[2]8,128
Illinois[4]		
Indiana	2,062	133,145
Iowa	538	1,076
Kansas	1,301	6,505
Kentucky	3,568	[2]27,832
Louisiana	[3]1,164	[2]9,079
Maine	1,884	62,172
Maryland	2,565	5,130
Massachusetts	2,788	27,880
Michigan	3,502	14,008
Minnesota	2,879	[2]22,456
Mississippi	470	[2]3,666
Missouri	6,998	48,986
Montana	672	20,160
Nebraska[4]		
Nevada	3,459	[2]26,980
New Hampshire	772	1,544
New Jersey	1,440	4,320
New Mexico	1,014	[2]7,909
New York	7,677	[2]59,881
North Carolina[4]		
North Dakota	180	360
Ohio	8,342	100,104[1]
Oklahoma	2,281	22,810
Oregon	2,988	[2]23,306
Pennsylvania	N/A	N/A
Rhode Island	252	[2]1,966
South Carolina	2,224	11,120
South Dakota	114	[2]889
Tennessee	2,717	35,321
Texas	10,072	80,576
Utah	653	1,306
Vermont	308	1,540
Virginia	4,017	20,085
Washington	3,005	9,015
West Virginia	1,336	6,680
Wisconsin	1,354	21,664
Wyoming	141	705
District of Columbia	804	[2]6,279
Puerto Rico	552	[2]4,306
Total	146,738	1,404,639

[1] Includes estimates by States of the number of unreported cases.

[2] Subcommittee estimate based on national average ratio of reported to unreported elder abuse cases (1/7.8).

[3] Because Louisiana discontinued its adult protective services program in August, 1988, this figure may be significantly understated.

[4] Did not respond to survey.

TABLE 11—States Which Received Complaints of Physical Abuse of Elderly

State	Yes	No
Alabama	X	
Alaska	X	
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho	X	
Illinois[1]		
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	
Massachusetts	X	
Michigan	X	
Minnesota	X	
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska[1]		
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina[1]		
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming	X	
District of Columbia	X	
Puerto Rico	X	
Total	49	0

[1] Did not respond to survey.

TABLE 12—States Which Received Complaints of Financial Abuse of Elderly

State	Yes	No
Alabama	X	
Alaska	X	
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho	X	
Illinois[1]		
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	
Massachusetts	X	
Michigan	X	
Minnesota	X	
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska[1]		
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina[1]		
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming	X	
District of Columbia	X	
Puerto Rico	X	
Total	49	0

[1] Did not respond to survey.

TABLE 13—States Which Received Complaints of Sexual Abuse of Elderly Persons

State	Yes	No
Alabama	X	
Alaska		X
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho	X	
Illinois[1]		
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	
Massachusetts	X	
Michigan	X	
Minnesota	X	
Mississippi	X	
Missouri	X	
Montana		X
Nebraska[1]		
Nevada		X
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina[1]		
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming		X
District of Columbia	X	
Puerto Rico	X	
Total	45	4

[1] Did not respond to survey.

TABLE 14—States Which Received Complaints of Psychological Abuse of Elderly

State	Yes	No
Alabama	X	
Alaska	X	
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho	X	
Illinois[1]		
Indiana	X	
Iowa		X
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	
Massachusetts	X	
Michigan	X	
Minnesota	X	
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska[1]		
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina[1]		
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming		X
District of Columbia	X	
Puerto Rico	X	
Total	47	2

[1] Did not respond to survey.

TABLE 15—States Which Received Complaints of Guardianship Abuse

State	Yes	No
Alabama	X	
Alaska		X
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho	X	
Illinois[1]		
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	
Massachusetts	X	
Michigan	X	
Minnesota	X	
Mississippi	N/A	
Missouri	X	
Montana	X	
Nebraska[1]		
Nevada		X
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina[1]		
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming	X	
District of Columbia	X	
Puerto Rico		X
Total	45	3

[1] Did not respond to survey.

TABLE 16—States Which Received Complaints of Rights Violations

State	Yes	No
Alabama	X	
Alaska		X
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho	X	
Illinois[a]		
Indiana	X	
Iowa	N/A	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	
Massachusetts	X	
Michigan	X	
Minnesota		X
Mississippi	N/A	
Missouri	X	
Montana	X	
Nebraska[a]		
Nevada		X
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina[a]		
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming		X
District of Columbia		X
Puerto Rico		X
Total	42	6

[a] Did not respond to survey.

TABLE 17—Is the Incidence of Elder Abuse Increasing?

State	Yes	No	No answer
Alabama	X		
Alaska	X		
Arizona	X		
Arkansas	X		
California	X		
Colorado	X		
Connecticut	X		
Delaware	X		
Florida	X		
Georgia	X		
Hawaii	X		
Idaho	X		
Illinois[1]			
Indiana	X		
Iowa	X		
Kansas	X		
Kentucky			X
Louisiana			X
Maine	X		
Maryland	X		
Massachusetts	X		
Michigan		X	
Minnesota	X		
Mississippi			X
Missouri	X		
Montana	X		
Nebraska[1]			
Nevada		X	
New Hampshire	X		
New Jersey	X		
New Mexico			X
New York	X		
North Carolina[1]			
North Dakota	X		
Ohio	X		
Oklahoma	X		
Oregon	X		
Pennsylvania	X		
Rhode Island	X		
South Carolina	X		
South Dakota	X		
Tennessee	X		
Texas	X		
Utah	X		
Vermont	X		
Virginia	X		
Washington	X		
West Virginia	X		
Wisconsin		X	
Wyoming	X		
District of Columbia	X		
Puerto Rico	X		
Total	42	3	4

---

[1] Did not respond to survey.

TABLE 18—States Which by Law Require Mandatory Reporting of Elder Abuse: 1980–90

State	1980	1985	1990
Alabama	X	X	X
Alaska		X	X
Arizona		X	X
Arkansas	X	X	X
California		X	X
Colorado			X
Connecticut	X	X	
Delaware			X
Florida	X	X	X
Georgia		X	X
Hawaii		X	X
Idaho		X	X
Illinois		X	
Indiana		X	X
Iowa		X	X
Kansas		X	X
Kentucky	X	X	X
Louisiana		X	X
Maine		X	X
Maryland			X
Massachusetts		X	X
Michigan		X	X
Minnesota	X	X	X
Mississippi			X
Missouri	X	X	X
Montana		X	X
Nebraska	X	X	X
Nevada		X	X
New Hampshire	X	X	X
New Jersey			
New Mexico			X
New York			
North Carolina	X	X	X
North Dakota			
Ohio		X	X
Oklahoma	X	X	X
Oregon		X	X
Pennsylvania			
Rhode Island		X	X
South Carolina	X	X	X
South Dakota			
Tennessee	X	X	X
Texas		X	X
Utah	X	X	X
Vermont	X	X	X
Virginia	X	X	X
Washington		X	X
West Virginia		X	X
Wisconsin			
Wyoming			X
District of Columbia		X	X
Puerto Rico			
Total	16	38	43

TABLE 19—States Which Favor Federal Legislation to Combat Elder Abuse

State	Create clearinghouse and hot-line	Grants to States for prevention and treatment	Victim shelter grants	Medicare home care benefits	National elder abuse system
Alabama	X	X	X	X	X
Alaska		X		X	X
Arizona	X	X	X	X	X
Arkansas	X	X	X	X	X
California	X	X	X	X	X
Colorado		X	X	X	X
Connecticut	X	X	X	X	X
Delaware	X	X	X	X	X
Florida	X	X	X	X	X
Georgia	X	X	X	X	X
Hawaii	X	X	X	X	X
Idaho	X	X		X	X
Illinois[1]					
Indiana	X	X	X	X	X
Iowa	X	X			
Kansas		X	X	X	X
Kentucky	X	X	X	X	X
Louisiana		X	X	X	X
Maine		X	X	X	X
Maryland	X	X	X	X	X
Massachusetts		X	X		X
Michigan	X	X		X	
Minnesota	X	X	X	X	X
Mississippi		X	X		X
Missouri	X	X	X	X	X
Montana	X				X
Nebraska[1]					
Nevada	X	X	X	X	X
New Hampshire		X	X	X	X
New Jersey	X	X	X	X	
New Mexico	X	X	X	X	X
New York		X	X	X	
North Carolina[1]					
North Dakota	X	X	X	X	X
Ohio		X	X	X	X
Oklahoma	X	X	X	X	X
Oregon	X	X	X	X	X
Pennsylvania	X	X	X	X	X
Rhode Island	X	X	X	X	X
South Carolina	X	X	X	X	X
South Dakota		X	X	X	X
Tennessee	X	X	X	X	X
Texas	X	X	X	X	X
Utah	X	X	X	X	X
Vermont	X	X	X	X	X
Virginia	X	X	X	X	X
Washington	X	X	X	X	X
West Virginia		X	X	X	X
Wisconsin	X	X		X	
Wyoming	X	X		X	X
District of Columbia		X	X	X	
Puerto Rico		X	X	X	X
Total	35	48	42	46	43

[1] Did not respond to survey.

APPENDIX II

SUBMITTED BY MR. HARSHBARGER

THE MIDDLESEX COUNTY DISTRICT ATTORNEY'S ACTION PLAN FOR CRIMES AGAINST THE ELDERLY

Scott Harshbarger
District Attorney

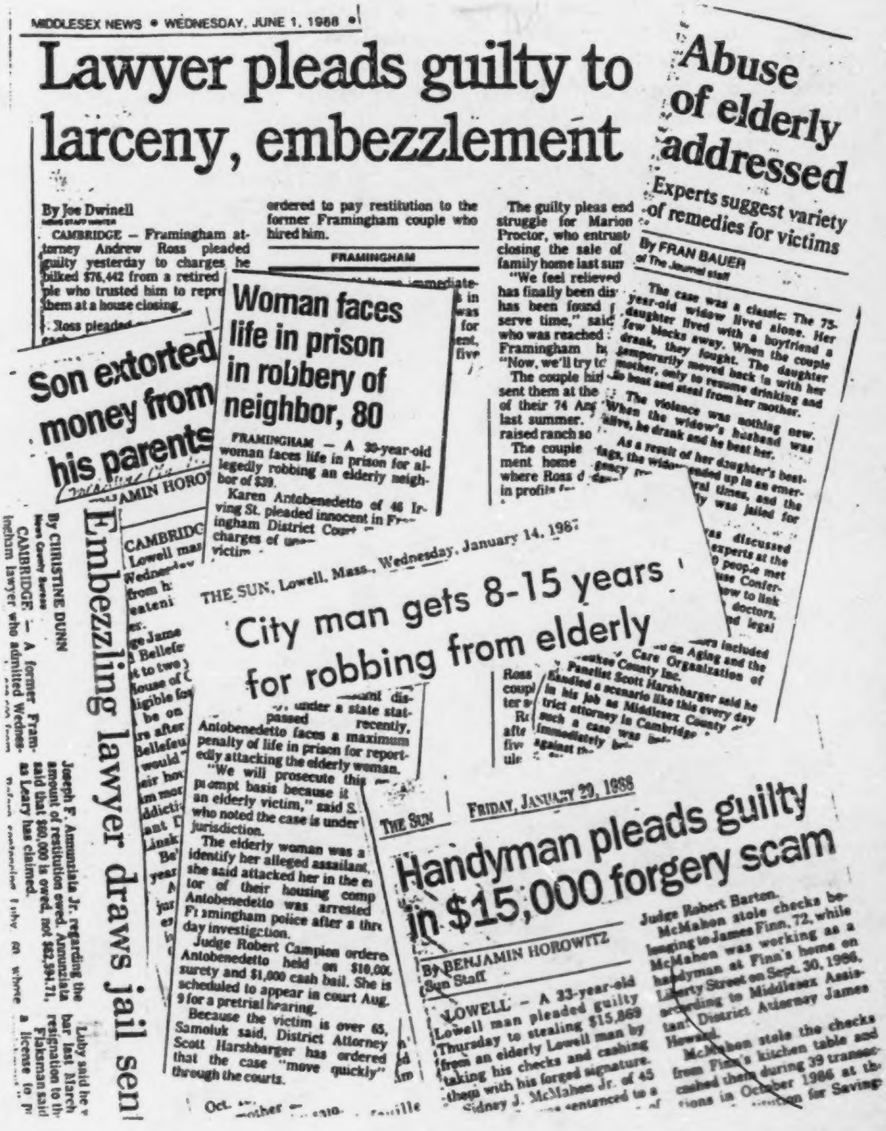
THE MIDDLESEX COUNTY DISTRICT ATTORNEY'S ACTION PLAN FOR CRIMES AGAINST THE ELDERLY

Scott Harshbarger
District Attorney

"Together, we can restore the confidence of the elderly in our system and, more importantly, empower them to once again take control of their lives and erase the fear of crime that increasingly immobilizes them and destroys their right to freedom, liberty and a life of power and dignity."

Scott Harshbarger
District Attorney
Middlesex County

September 30, 1988



MIDDLESEX NEWS • WEDNESDAY, JUNE 1, 1988

Lawyer pleads guilty to larceny, embezzlement

By Joe Dwinell

CAMBRIDGE – Framingham attorney Andrew Ross pleaded guilty yesterday to charges he bilked $76,442 from a retired ple who trusted him to repre them at a house closing.

Ross pleaded

ordered to pay restitution to the former Framingham couple who hired him.

The guilty pleas end struggle for Marion Proctor, who entrust closing the sale of family home last sum

"We feel relieved has finally been dis has been found serve time," saic who was reached Framingham h "Now, we'll try tc

The couple hir sent them at the of their 74 Ar last summer. raised ranch so

The couple ment home where Ross d in profits

Abuse of elderly addressed

Experts suggest variety of remedies for victims

By FRAN BAUER
of The Journal staff

The case was a classic: The 75-year-old widow lived alone. Her daughter lived with a boyfriend a few blocks away. When the couple drank, they fought. The daughter temporarily moved back in with her mother, only to resume drinking and to beat and steal from her mother.

The violence was nothing new. When the widow's husband was alive, he drank and he beat her.

As a result of her daughter's beatings, the widow ended up in an emergency ral times, and the ly was jailed for

as discussed experts at the people met Conferw to link doctors, d legal

included on Aging and the Care Organization of County Inc.

Panelist Scott Harshbarger said he handled a scenario like this every day in his job as Middlesex County trict attorney in Cambridge such a case was immediately against

---

Woman faces life in prison in robbery of neighbor, 80

FRAMINGHAM – A 30-year-old woman faces life in prison for allegedly robbing an elderly neighbor of $39.

Karen Antobenedetto of 46 Irving St. pleaded innocent in Framingham District Court charges of victim

under a state statute passed recently, Antobenedetto faces a maximum penalty of life in prison for reportedly attacking the elderly woman.

"We will prosecute this prompt basis because it an elderly victim," said S. who noted the case is under jurisdiction.

The elderly woman was a identify her alleged assailant, she said attacked her in the e tor of their housing comp Antobenedetto was arrested Framingham police after a thr day investigation.

Judge Robert Campion ordere Antobenedetto held on $10,00 surety and $1,000 cash bail. She is scheduled to appear in court Aug. 9 for a pretrial hearing.

Because the victim is over 65, Samoluk said, District Attorney Scott Harshbarger has ordered that the case "move quickly" through the courts.

Son extorted money from his parents

AMIN HORO

CAMBRIDG Lowell ma Wedne from h eateni

Embezzling lawyer draws jail sen

By CHRISTINE DUNN

CAMBRIDGE – A former Framingham lawyer who admitted Wednes

Joseph F. Ammnziata Jr. regarding the amount of restitution owed. Annunziata said that $80,000 is owed, not $82,594.71, as Leary has claimed.

Luby said he bar last March resignation to th Flaksman said a license to p

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THE SUN, Lowell, Mass., Wednesday, January 14, 1987

City man gets 8-15 years for robbing from elderly

THE SUN FRIDAY, JANUARY 29, 1988

Handyman pleads guilty in $15,000 forgery scam

By BENJAMIN HOROWITZ
Sun Staff

LOWELL – A 33-year-old Lowell man pleaded guilty Thursday to stealing $15,869 from an elderly Lowell man by taking his checks and cashing them with his forged signature.

Sidney J. McMahon Jr. of 45 sentenced to a

Judge Robert Barton.

McMahon stole checks belonging to James Finn, 72, while McMahon was working as a handyman at Finn's home on Liberty Street on Sept. 30, 1986, according to Middlesex Assistant District Attorney James Howard.

McMahon stole the checks from Finn's kitchen table and cashed them during 39 transactions in October 1986 at the for Saving

CONTENTS

Introduction by District Attorney Scott Harshbarger 1

Priority Focus on Cases Involving Elder Victims 5

Financial Exploitation of the Elderly: Priority Prosecution of These White Collar Crimes 6

- Financial scams by strangers 6
- Financial abuse by family members 7
- Financial exploitation by a professional fiduciary 7

Reporting of Abuse of the Elderly: Guidelines and Protocol 8

- Case referral and assignment 8
- Initial investigatory response 9
- Handling ongoing cases 9
- Closing out a case 10

Training, Education and Data Collection 10

- Police 11
- Protective service workers 11
- Hospitals, clinics and other medical service providers 11
- Financial institutions 11
- Data collection 12

Crime Prevention and Awareness 12

THE MIDDLESEX COUNTY DISTRICT ATTORNEY'S ACTION PLAN FOR CRIMES AGAINST THE ELDERLY

An Introduction

By
Scott Harshbarger

As District Attorney of Middlesex County since 1983, I have made crimes against the elderly a priority in my office. Our experience has taught us that the problem of crime against older Americans, particularly economic crime and elder abuse, is extremely serious and oftentimes complex.

My concern about crimes against the elderly initially grew out of the recognition that the public generally had lost confidence in the capacity of government and the criminal justice system to protect it against crime. It was obvious that the lack of confidence was more extreme for the elderly, many of whom, because of their age and changed status alone, feel an enhanced sense of loss of control and a sense of vulnerability in their lives. It was clear to me, then and now, that the elderly had to be a focus of specific and special law enforcement and prosecutorial attention, and that we had to do all we could so that they would not feel compelled, or be forced, to live their retirement years in fear of being victims of a crime.

The reality which all of us must recognize is that older Americans, like the poor and children, because of their relative or perceived powerlessness, suffer most dramatically both from the effects of actual crime and from the fear of crime. As victims, they are wounded several times over: their sense of security is eroded; their fear of lost control is heightened; they have a real fear of reporting and intimidation triggered by the crime; and they often believe, tragically, that they have brought the crime upon themselves because of their age alone.

Beginning with these basic concerns, our initial focus was on violent and street crime involving elderly victims. In order to deal with the fact that an elderly victim is more likely than someone younger to be traumatized by the crime itself and to be "re-victimized" by having to re-live the incident and participate in the criminal justice system, we established a policy of immediately assigning an experienced assistant district attorney and a victim witness advocate to every case with an elderly victim. The victim witness advocate's role was and remains crucial in encouraging the elderly victim to participate. By being present to guide the victim through the system, provide support, explain the process and keep him or her informed at every stage of the case, the advocate does a great deal to demystify the criminal justice process and make it a far more supportive place.

In addition, we wanted to instill confidence that, if the victim participated, we would ensure swift and effective prosecution and punishment of the offender. Therefore, cases with elderly victims were designated matters for priority prosecution, in order to move the cases quickly through the system, enable the victims to put the incident behind them and get on with their lives, and see that, in fact, there was appropriate punishment.

During this period, the Public Protection Bureau in my office, a special unit of prosecutors who handle "white collar" crime, began to focus enforcement resources on economic crime and consumer fraud. The experience of police officers and prosecutors in Middlesex County showed that elder citizens are more often selected as targets of economic crimes than any other type of offense. Because they often live alone, and particularly in suburban communities, the elderly are often the chosen victims of financial and home improvement scams, larceny by family members and various forms of "fiduciary" embezzlement by a family lawyer, accountant or investment counselor. However, our experience also showed that for a variety of reasons, many of these crimes were not being reported by the victims at all, or not until they were discovered by others, often after all the victim's assets were gone. Our understanding of the victimization of the elderly, and the "under-reporting" syndrome, began to expand and evolve. With the Public Protection Bureau in place, we were able actively to encourage reporting and allocate appropriate resources to the investigation and prosecution of these financial abuse offenses within an existing organizational structure.

As we continued to reach out to the senior citizen community and agencies serving them to encourage crime awareness and reporting, and to inform them about the services and support we could offer, we gained a new understanding of the most tragic type of crime affecting older Americans, elder abuse and neglect. At the end of 1982, a mandatory elder abuse reporting law went into effect in Massachusetts. The law required various professionals, including doctors, police, social workers and others, to report suspected incidents of elder abuse to the state-wide Executive Office of Elder Affairs or its designated local affiliates; these agencies in turn were obligated by the statute to refer cases of "serious abuse" to the District Attorney.

Abuse of the elderly, whether physical, sexual, emotional or financial, had historically been shrouded in a veil of secrecy and protected by the family bond. Prosecutors and the criminal justice system were now being mandated to play a role in a societal problem which had previously been considered a private, family matter.

Similarities between child abuse and elder abuse cases were apparent. A law mandating that serious child abuse cases be reported to the District Attorney went into effect in 1983.

Prior to passage of the law, child abuse too had often been kept hidden within the confines of the family, and not reported to law enforcement agencies because of fear of retaliation and embarrassment on the part of the victim or the relationship between the perpetrator and the victim.

There was, however, one distinct and critical difference between our experience with the two different mandatory abuse reporting laws. Almost immediately after the child abuse reporting statute went into effect, the number of reports of child abuse that we received from the Department of Social Services dramatically increased. That has not been our experience with the elder abuse reporting law. Despite the existence of the statute, there have been relatively few reports, averaging approximately 12 to 15 per year in Middlesex County through 1987. We were very concerned by these numbers, because of the increasing national evidence that incidence of elder abuse was far greater than the number of reports indicated. In a county of 1.4 million people and 54 cities and towns, only 12 to 15 reports of serious abuse in one year seemed unrealistically low. One explanation offered was that, since the victims in these cases were adults and thus presumptively competent, the under-reporting was due to the victims' decision not to complain or to mandatory reporters' difficulty in assessing whether injuries and conditions they observed were really caused by abuse. However, the analogy of elder abuse cases to domestic violence seemed an apt rebuttal, since domestic violence reports, like reports of child abuse, had also risen dramatically after passage of a domestic abuse law in Massachusetts. Hence, it seemed to us that the problem was far more basic: that while some victims might have been declining to complain or report, others were not competent to do so, and mandatory reporters were failing to comply with the law.

In 1988, I took steps within my office to address the growing problem of various forms of family violence, including elder abuse. Through the reallocation of existing resources, crimes against the elderly, along with child abuse, juvenile offenses, domestic violence and child support enforcement cases were put under the "umbrella" of a new Family and Community Crimes Bureau. To address the issue of elder abuse in particular, through the Bureau we have initiated an interdisciplinary approach, drawing on lessons we learned from handling hundreds of child abuse cases in the last four years. We have worked closely with protective services agencies and police to provide joint training programs and develop guidelines for handling elder abuse cases. Our goal is to establish ongoing relationships that encourage the protective service workers and police to report and refer more incidents of elder abuse, and enable us all to work together constructively on these cases.

* * *

The Office of the Middlesex County District Attorney's Action Plan For Crimes Against the Elderly is the product of almost six years of experience in prosecuting and investigating crimes against senior citizens, in having assistant district attorneys and victim witness advocates working directly with elderly victims, and in reaching out to work with police and senior citizen organizations. The Plan has several distinct parts:

*Priority prosecution and special handling of street and violent crime cases involving elder victims;

*White collar prosecution of economic crime and financial exploitation of elderly citizens;

*Coordinated multidisciplinary response to cases of elderly abuse;

*Training, education and data collection;

*A crime awareness and prevention program.

This Action Plan is an effort to establish an aggressive, efficient and effective approach aimed at protecting the rights of the elderly and preventing crimes against them. We are determined to implement the Action Plan on all fronts, in all cases where the elderly are victims of crime, whether by strangers, by people they know or by those in a familial or custodial relationship to them. And when crimes against older Americans are reported, our goal is to ensure, by comprehensive, multidisciplinary work, that the elderly are not victimized a second time by the criminal justice system. I am convinced that through increased public awareness, better training of the professionals who deal with the elderly, and enhanced awareness among elders themselves of the resources and assistance criminal justice agencies can provide, we will encourage the reporting of crimes, and in turn, we will be able to respond more effectively to crimes that are reported.

Together, we can restore the confidence of the elderly in our system and, more importantly, empower them to once again take control of their lives and erase the fear of crime that increasingly immobilizes them and destroys their right to freedom, liberty and a life of power and dignity.

1. PRIORITY FOCUS ON CASES INVOLVING ELDER VICTIMS

The Family and Community Crimes Bureau monitors all criminal cases in this Office that involve an elder victim. Assistant district attorneys (ADAs) and victim witness advocates (VWAs) report each such case as it comes into the office to the Bureau, and also provide periodic updates on case progress and disposition. Case tracking, however, is only one aspect of a multi-faceted effort to ensure sensitive, effective and efficient handling of these cases.

In addition to the monitoring effort, the Office designates all criminal cases in which the victim is elderly as "priority prosecutions," thereby ensuring a special focus on the case in terms of expedited handling, sentencing recommendations and victim support. In addition, more serious cases involving elder victims, which are prosecuted in the Superior Court, are all specially supervised by an experienced ADA to enhance effective case presentation, a careful review of dispositional recommendations and consistency in handling. Moreover, we review all cases to make sure that, if possible under the particular facts, we charge defendants under statutes that provide for enhanced penalties because of the age of the victim.

Some actual case examples help to illustrate these policies. In a case involving armed burglary and assault against a senior citizen, the defendant received the sentence recommended by this Office, 30 to 35 years in state prison. In another case, this Office prosecuted a defendant who broke into the residence of an elderly man. The defendant received a five to seven year state prison sentence. In each case, the prosecutor routinely "upped the ante," in making her sentencing recommendation, solely because the victim was a senior citizen.

One of the most critical aspects of our efforts in this area is the insistence that a VWA with training and experience in dealing with elder crime victims be assigned to every case that has a victim over 65 years of age, regardless of whether or not the case involves a serious offense. The VWA helps to explain the criminal process and the roles various participants play in it, serves as the victim's liaison with the prosecutor and police, offers ongoing support, and often helps to link the elder victim with necessary social or medical services. The goal is to reduce the sense of vulnerability and trauma that often accompanies an elder person's participation in a criminal prosecution.

Examples again provide useful illustrations. In a case of elder abuse, a 33-year-old man was charged with threatening to kill his 66-year-old mother and 74-year-old stepfather, and extorting money from them. The evidence indicated that there had been long-term abuse by the son and as a result, the elderly couple lived in fear of him. An experienced VWA was immediately assigned to the case. She worked regularly with the victims, explaining the court system, preparing them to testify at trial and generally providing support. Both victims were able to testify at trial without being traumatized. The defendant was convicted and sentenced to incarceration at the House of Correction. By all accounts, the case could not have been prosecuted without the VWA providing guidance and support to the elderly victims.

In another elder abuse case, a 74-year-old man was assaulted by his son with a hatchet. Although the victim was not seriously injured, investigators learned that the victim and his wife had suffered through years of emotional, mental and occasional physical abuse. A VWA worked closely with the victim and learned that the victim did not want his son incarcerated, but did want to be protected from him. The court accepted the ADA's recommendation of a suspended sentence, the suspension being based on the condition that the son have no contact with the parents and that he seek alcohol and drug treatment. The VWA was able to play a significant role in the case by ensuring both that the desires of the victim were respected and represented to the court and that he would be protected from any future abuse.

2. FINANCIAL EXPLOITATION OF THE ELDERLY: PRIORITY PROSECUTION OF THESE WHITE-COLLAR CRIMES

The experience of police officers and prosecutors in Middlesex County is that elder citizens are more often chosen as targets, and are more likely to be the victims, of financial crimes than any other type of offense. We have also found, however, that with enhanced publicity and reporting, as well as effective prosecution, some of these financial crimes can be deterred or prevented. Three categories of financial crimes seem to be dominant: financial scams or "flim-flam" operations, usually planned and perpetrated by strangers; larceny or misuse of funds by family members or those with regular, ongoing contact; and various forms of "fiduciary" embezzlement by a family lawyer, accountant or investment counselor.

*Financial Scams by Strangers

The Family and Community Crimes Bureau seeks to serve as a clearinghouse of information about all types of "white-collar" scams that may come to the attention of any police department in Middlesex County or the District Attorney's Office. We request all police to notify the Bureau of any incident reports, arrests, etc., that may involve a scam operation. The Bureau is responsible for ensuring that: (1) insofar as charges have been brought in a District Court, the case is reviewed and monitored, and the assigned ADA is aware of the "scam" aspect of the case; (2) if there is a case involving significant amounts of money and/or the same type of scam operation in a number of different communities, the Public Protection Bureau of this Office, with its expertise in handling economic crime cases and its superior investigative capacities, reviews the case and, if appropriate, handles it; and (3) other police departments in neighboring communities as well as elder service agencies are made aware of the operation.

When financial scams are reported to the District Attorney's Office, there is a swift and meaningful response. For example, this Office prosecuted three men who had bilked a 67-year-old woman of about $113,000 in a home repair scheme. It started when strangers knocked on her door and offered to paint her home. After the men began painting, they convinced the woman that many other repairs were needed to the single-family house. The scheme finally came to light when the victim confided her concerns to a friend, who asked that it be investigated.

*Financial Abuse by Family Members

The Family and Community Crimes Bureau also serves as a reporting center and resource for these types of cases. Through training programs and meetings we seek to encourage protective services agencies and their workers to look for and inform the Bureau of cases of familial or caretaker financial abuse within the boundaries of the agencies' reporting authority. The Bureau reviews any such case that is reported and, if criminal prosecution appears possible and appropriate, assigns the matter to an ADA and a VWA and monitors its progress. The Bureau also tracks every familial financial abuse case involving an elder victim that comes into this Office through police action or any other means. The Bureau refers the most serious of these cases to the Public Protection Bureau for its review and possible handling.

*Financial Exploitation by a Professional Fiduciary

Cases involving embezzlement or larceny of funds from an elder person by a lawyer, accountant, or other individual in a fiduciary relationship with the victim are reported to the District Attorney's Office by a variety of sources, including the victim or victim's family, professional disciplinary bodies such as the Board of Bar Overseers, and police. Virtually all of these cases are referred to the Public Protection Bureau within the Office, and to the extent the case is actionable, the staff of that Bureau investigate and prosecute it.

For example, the Public Protection Bureau prosecuted an attorney who had stolen over $76,000 from a retired couple who trusted him to represent them at a house closing. The defendant was sentenced to five years in state prison and ordered to pay full restitution. The attorney was later disbarred by the Massachusetts Supreme Judicial Court.

3. REPORTING OF ABUSE OF THE ELDERLY: GUIDELINES AND PROTOCOL

Massachusetts has enacted a mandatory reporting law for cases of suspected physical and emotional abuse and neglect of elders, Mass. Gen. Laws, c. 19A, sec. 14-26. "Abuse" is defined in the statute as "an act or omission which results in serious physical or emotional injury to an elderly person"; financial abuse is not included. A person is an "elderly person" if he or she is 60 or older. Under the statute, a variety of designated professionals -- police officers, physicians, nurses, elder services workers, to name a few -- must report such cases to the State Executive Office of Elder Affairs (EOEA) or one of its designated local protective services agencies. The statute in turn directs EOEA and its designated agencies to refer all reported cases of "serious abuse" (a term undefined in the law), as well as all deaths reasonably suspected to be caused by abuse, to the appropriate District Attorney for further investigation and possible prosecution.

The mandatory reporting law became operational in 1983. In the first five years of its existence, only an average of 12 to 15 cases of "serious abuse" were annually reported or referred to our Office in Middlesex County. In analyzing the reasons for this low rate of referrals, we concluded that the major reason seemed to be institutional distrust on the part of protective services agencies and workers towards law enforcement, the same factor that impeded child abuse case referrals in the early days of the Massachusetts child abuse reporting law. Misunderstanding as well as lack of contact and coordination severely limited the number of "serious abuse" cases that were reported to the District Attorney. To help remedy this problem, in June of 1988, in consultation with EOEA, we adopted a comprehensive set of guidelines which have been sent to every one of the six protective services agencies in Middlesex County, and they serve as a major focus of our ongoing training programs for EOEA workers. The guidelines provide a detailed explanation of how the District Attorney's Office handles each referral, and they emphasize our commitment to continuous information-sharing and cooperation with the reporting protective services worker and agency as the case is being handled in this Office.

The key points of our approach to elder abuse case referrals, as set forth in the guidelines, are these:

*Case Referral and Assignment

Every "serious abuse" case is immediately referred to the Family and Community Crimes Bureau which acts as the central clearinghouse. The Chief or Deputy Chief of the Bureau then:

** reviews the report;
** decides whether it calls for an emergency response; and
** refers it to the appropriate District Court Supervisor for immediate (same day) assignment to an ADA and a VWA.

*Initial Investigatory Response

The assigned ADA or VWA contacts the reporting protective services worker on the day of the referral if it is an "emergency" case, or otherwise within two days. The major purpose of this initial contact is to assess the victim's immediate safety or lack thereof. The ADA or VWA tries to learn as much as possible about the victim, the perpetrator, their relationship, the nature and frequency of the abuse, the domestic situation, the knowledge and attitude of both towards law enforcement and District Attorney involvement, and the general situation.

After the initial contact, the ADA and the VWA work with the assigned protective services worker to formulate a plan to protect the victim if he or she is at immediate risk. This plan may include: working to separate the victim and the perpetrator, making application for a civil protective order under the domestic abuse law, initiating criminal charges, and/or arrest.

Once steps have been taken to ensure the elder victim's safety, the ADA or the VWA meets with the victim within a few days, in order to evaluate personally the situation and to discuss with the victim the options available and, where appropriate, basic aspects of a criminal case.

*Handling Ongoing Cases

Following the visit to the victim, the ADA and the VWA review the case, confer with the protective services worker, decide on a course of action, and begin to implement it.

The alleged perpetrator is likely to be a close family member, or one who has an ongoing relationship with the victim. Therefore, our policy is to bring criminal charges only after consultation with the victim, any supporting family members and the protective services worker. However, the ADA and VWA explain to all such victims that while their wishes and concerns about prosecution will be given full consideration, the decision whether to initiate criminal charges ultimately rests with the Commonwealth.

*Closing Out A Case

A case is closed when one of the following occurs (if more than one, then after the last event that occurs):

** a permanent protective order under the domestic abuse law is granted or the original order is vacated;

** a protective order is sought and the application denied;

** after consultation, the victim decides not to seek any such order;

** criminal charges are brought, prosecuted and disposition occurs;

** the office, after consultation with the victim and protective services worker, determines no criminal charges can or should be brought, and this decision is communicated to the victim and the protective services worker.

When a decision to close is made, the ADA and VWA notify the victim, any involved family member, the protective services worker, the protective services agency and EOEA of the action in writing, including the reasons for closing the case.

We believe that these guidelines, in conjunction with our ongoing training programs for protective services workers, police and other mandated reporters, will serve as useful vehicles for encouraging case referrals to this Office. They should also help to establish constructive working relationships among the various professionals who may be involved in a case of elder abuse.

4. TRAINING, EDUCATION AND DATA COLLECTION

Research, both national and local, indicates far greater incidence rates of elder abuse and related crimes against the elderly than are being reported to the District Attorney's Office. Underreporting of these crimes is a widespread problem that severly restricts the effectiveness of any law enforcement efforts and the ability to prevent these crimes from occurring or escalating.

Education and training of those professionals who come in contact with elder persons on a regular basis are essential first steps in seeking to address the issue of underreporting. Accordingly, a major focus of our elder program is the provision of training programs that explain and describe:

**Warning signals and indicators of possible physical and emotional abuse or neglect;

**How and where to report such abuse once it is suspected;

**Reporting deaths where abuse is suspected to be the precipitating cause,

**The prevalence of financial exploitation accompanying physical and emotional abuse; and

**Reporting cases of suspected financial exploitation to the District Attorney, etc.

We have initially targeted four major groups for these training programs:

*Police

Police are mandated reporters of suspected elder abuse under the Massachusetts Elder Abuse Law, but it appears that few officers have been trained to recognize abuse or know about their duty to report cases of suspected abuse or deaths that may be abuse related.

*Protective Services Workers

We have provided several training sessions for all the protective services workers employed by the EOEA and its designated protective services agencies in Middlesex County. The training seeks to inform these workers about the ways that the District Attorney's Office handles abuse cases reported to us, to air and alleviate the institutional distrust between the protective services community and a prosecutor's office, and to encourage them to share information about possible financial exploitation of elders. The overall goal is to bring about greater reporting by these workers and agencies of "serious abuse" cases and abuse-related deaths to the District Attorney.

*Hospitals, Clinics, and Other Medical Service Providers

Although professional staff of hospitals and clinics, including physicians, nurses and social workers, are all mandated reporters of elder abuse cases, very few cases of elder abuse or neglect are reported by them. ADAs and VWAs try to meet with representatives of hospitals, clinics, and other medical institutions to make them more aware of their reporting responsibilities and encourage the development of internal protocols for handling cases of suspected abuse or neglect.

*Financial Institutions

Banks and other financial institutions have a potential role to play in spotting cases of financial exploitation of elderly clients, insofar as account withdrawals, fund transfers, etc. may indicate a possible problem. Clearly the privacy and autonomy of elder bank clients must be respected, but within these parameters, we seek to discuss and identify with bankers signs of possible financial exploitation and encourage reporting those instances.

*Data Collection

Finally, there is a great need to collect information about the numbers and types of criminal cases with elder victims which do currently exist as well as police incident reports involving elders. The Bureau of Family and Community Crimes is working with the individual police departments in Middlesex County to establish either computerized or manual systems for identifying all reported incidents or cases involving a victim or reporting party who is 60 or older.

5. CRIME PREVENTION AND AWARENESS

Based on our experience, it is clear that many crimes against the elderly, both street and white-collar, plus many "serious abuse" cases, could be prevented if reported earlier or with adequate information being made available at the time the report is made. One of our major goals, beginning with the publication of our guide, Security at Home and Away: A Guide for Older Americans several year ago, is to work with elder citizens and elder citizen groups, to provide them with information about these crimes, to emphasize prevention and to encourage reporting. To further that goal, the Family and Community Crimes Bureau has organized a community education "road show" with a "cast" consisting of a police officer, a protective services worker, a banker, and an ADA or VWA. Within targeted communities in Middlesex County the "show" goes to elder housing projects, senior citizen centers, community organizations -- anywhere that elders congregate -- and puts on a program that includes: a film; advice offered by the police officer about personal safety and home protection; information provided by the protective services worker about reporting elder abuse, and the kinds of protection and other services that are available to deal with such abuse; a presentation about financial exploitation by family members and others as well as flim-flam operations, and how, why and to whom these should be reported; and information about the District Attorney's role in investigating and prosecuting crimes against the elderly and our commitment to provide support and services to the victim.

The goals here are to assist elder citizens in working to prevent crimes and to address again the problem of underreporting. We hope that through these personal contacts with elders and organized elderly groups, we make them aware of the support that is available to them, and help to give to them the tools to control and live their lives free from crimes, abuse, and the fear of both.

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For further information or additional copies, please contact Margot Botsford, Chief, or Jane Tewksbury, Assistant Chief, of the Family and Community Crimes Bureau at (617) 494-4823, or write to their attention at: The Middlesex County District Attorney's Office, 40 Thorndike Street, Cambridge, MA 02141.

OFFICE OF THE DISTRICT ATTORNEY
OF MIDDLESEX COUNTY

CRIMES AGAINST THE ELDERLY: PRELIMINARY FINDINGS

by

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Juvenile Justice Project
Family and Community Crimes Bureau

November, 1989

Scott Harshbarger
District Attorney

PREFACE

CITIZENS OF MIDDLESEX COUNTY:

The problem of elder abuse and victimization must no longer be ignored. In September, 1988, I presented you with my Action Plan for Crimes Against the Elderly. In that plan, I outlined our major objectives in combatting elder abuse and crimes against the elderly:

*Priority Prosecution and special handling of street and violent crime against elder victims;

*Prosecution of economic crime and consumer fraud against, and financial exploitation of, elderly citizens;

*Coordinated multidisciplinary response to cases of elder abuse;

*Training, education and data collection; and

*Crime awareness and prevention programs.

I am proud to report that we have made significant progress in each of these areas and have been asked by the Executive Office of Elder Affairs to serve as a model for other District Attorneys' offices across the state. This study, Crimes Against the Elderly: Preliminary Findings, is the result of the time and effort of my staff research analyst, Dr. Amy Maizel Seeherman. It represents our initial data collection effort, as proposed in the Action Plan.

Through a preliminary look at 104 cases involving crimes against the elderly in Middlesex County between May, 1988, and May, 1989, Dr. Seeherman arrived at some noteworthy preliminary conclusions;

First, crimes against the elderly were generally committed by a male against a female with more than 50% of the perpetrators being members of the victim's family.

Second, the majority of the incidents were of an assaultive nature and 49% resulted in criminal complaints being issued.

Third, of those cases where a complaint was issued, the majority (62.7%) of the perpetrators were convicted and, of those convicted, more than one-half were incarcerated.

While the study is limited by the relatively small sample size and the archival nature of the underlying data, the conclusions reached are instructive and will prove helpful to all of us in meeting the continuing problem of crimes against the elderly. With increasing life expectancies, there will be more and more elderly citizens, and if we fail to address the problem of crimes against the elderly, we will see more and more elderly victims. We must take steps now to prevent crimes against the elderly by strangers or family members, and to respond promptly to those elders who have been victimized. The criminal justice system cannot resolve the problem alone - everyone in the community must do his or her part. This study, describing the nature of the problem, is but a first step in that process.

We all need to continue to reach out to older Americans and to the agencies serving them to inform them about the services and support we can offer collectively. We need to increase our understanding of the victimization of the elderly in all of its forms; physical, sexual, emotional and financial, so that we can develop long-term generational responses to the problem. We must also develop and support programs which will prevent elder victimization, and ensure they are priorities when private and public resources are allocated. Specifically, priority must be given to programs which provide financial assistance and legal support to elders; adequate and affordable health care; adequate resources for elder care-giving agencies and state social service programs; and guarantee suitable housing. We hope studies such as this one will help to increase the public's awareness of the nature of the problem and with that increased understanding and the development of a comprehensive, multidisciplinary response to the problem, I hope we will be better able to meet the challenge of justice in the 1990's: To ensure that a longer life does not mean a loss in the quality of life for our senior citizens.

Sincerely,

Scott Harshbarger

INTRODUCTION

The office of the Middlesex County District Attorney's Action Plan For Crimes Against the Elderly emerged as a result of the following factors: (1) it had become increasingly clear to the District Attorney that the social problem of crimes against the elderly warranted immediate attention. Although individuals age 65 and older had the lowest victimization rates of any age group according to the National Crime Survey (National Crime Survey 1980-1985), the crimes committed against the elderly are often more serious; there is a disproportionate impact of crime on the economic, physical and emotional status of the elderly (Goldsmith, 1977). In essence, the human costs of crime against the elderly are very significant. And, (2) recognition by the District Atttorney of the erosion of public confidence in the power of the criminal justice system to protect citizens against crime. This loss of confidence is particularly prevalent among the elderly.

The objectives of this plan are:

(1)"Priority prosecution and special handling of street and violent crime cases involving elder victims;"

(2)"White collar prosecution of economic crime and financial exploitation of elderly persons;"

(3)"Coordinated multidisciplinary response to cases of elderly abuse;"

(4)"Training, educaton and data collection;"

(5)"A crime awareness and prevention program."*

The Family and Community Crimes Bureau (FCC) in the Middlesex County District Attorney's Office serves as the "central clearinghouse" for the referral and assignment of all cases of elder abuse and neglect, and the monitoring of all criminal cases that involve an elder victim. As a part of this initiative, it is the policy of the District Attorney's Office to treat criminal cases in which the victim is elderly as "priority prosecutions." This delineation ensures special handling of the case in the following ways: expeditious prosecution, enhanced sentencing recommendations, and special victim support.

*For a complete description of this plan, see The Middlesex County District Attorney's Action Plan For Crimes Against the Elderly by L. Scott Harshbarger, September, 1988

In light of the aforementioned goals specified in the Action Plan, a systematic investigation of crime against the elderly (adults age 60 or older) was undertaken. This small exploratory-descriptive study represents a pioneering effort to examine the nature of crimes against the elderly in a sample of cases screened into the Family and Community Crimes Bureau from May, 1988 through May, 1989.

DATA COLLECTION

One hundred twenty-three cases were originally referred to the Family and Community Crimes Bureau from May, 1988 through May, 1989. However, nineteen cases were initially excluded from statistical computation for the following reasons: (1) there was an excessive amount of missing data (16 cases); and (2) charges of abuse were never substantiated (3 cases). Following elimination of these surveys from the data collection effort, the sample under study consisted of 104 cases.

To extrapolate the appropriate information from case files, a case abstract form was developed (See Exhibit A). Data have been collected for the following variables: court, sex of the perpetrator, sex of the victim, age of the perpetrator, age of the victim, nature of the incident, type of offense, relationship of the perpetrator to the victim, injuries to the victim, protective service involvement, results of the investigation and type of sentence.

LIMITATIONS OF THE STUDY

In summary, this preliminary research effort examined cases of crime against the elderly that were referred to the FCC Bureau from May, 1988 through May, 1989. In using this research strategy, certain limitations were evident. Due to the reliance on archival data, there was an absence of data on several surveys that ultimately led to their exclusion from the sample.

Another limitation was the lack of control or comparison groups. Finally it was difficult to determine how representative this group of elderly crime victims is of the population of elderly victims of crime. However, despite these limitations, this small study represented a springboard for future research investigations concerning criminal victimization of the elderly.

RESEARCH FINDINGS

CHARACTERISTICS OF VICTIMS AND PERPETRATORS

One hundred-four (104) cases of crime against the elderly constitute the sample of the study. Eighty-five (81.7%) of the perpetrators of crime were male and nineteen (18.3%) were female (See Table 1). The largest proportion of perpetrators were found in the 30-39 year old age category (See Table 2).

The data also revealed that the majority of victims of elder mistreatment were women (See Table 3). This finding is consistent with much of the past systematic investigations of elder abuse. A more current study, however reported that "roughly equal numbers of men and women were victims of mistreatment, albeit women suffered more serious abuse." (Pillemer and Finkelhor, 1988). The largest proportion of victims of crime in this study were found in the 60-70 year old age group (See Table 4).

Finally, in the present study, the rubric "crime against the elderly" includes a variety of offenses from elder abuse to economic crime. In light of this fact, it is not surprising that over one quarter of the perpetrators (26.2%) were not

TABLE 1

Crime Against the Elderly
(May 1988 - May 1989)

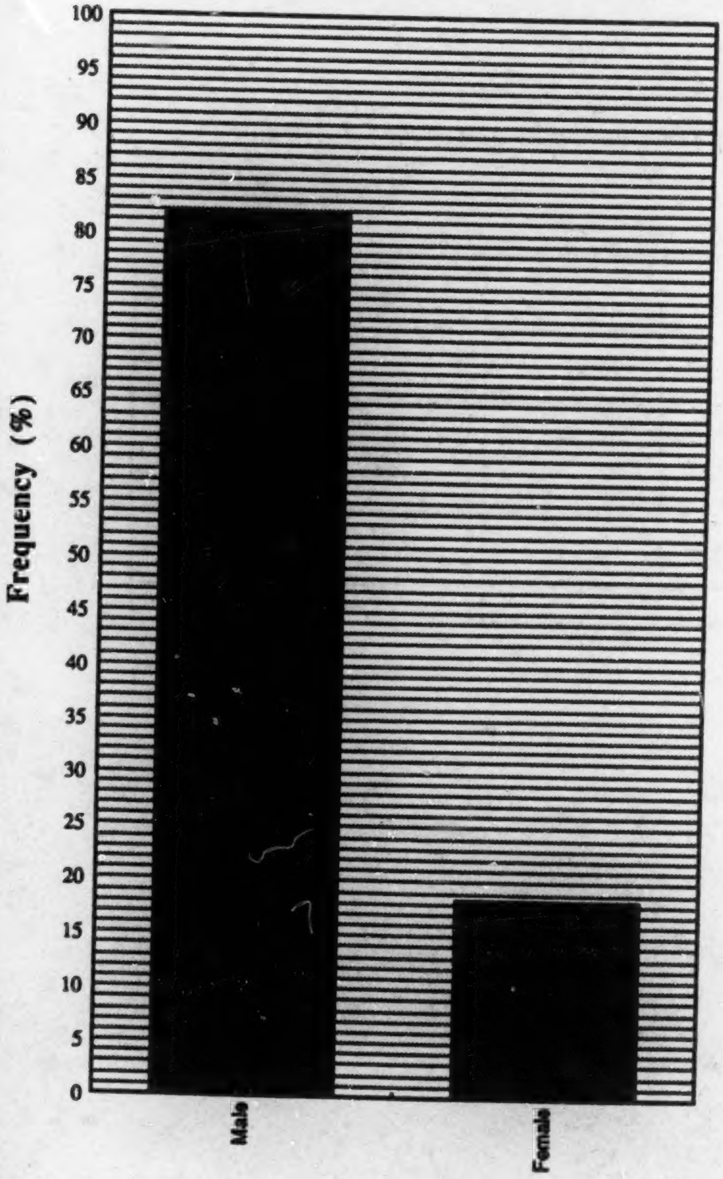
Frequency Distribution by Sex of the Perpetrator

Bar:	Sex of the Perpetrator:	Count:	Percent:	
1	Male (1)	85	81.7	- Mode
2	Female (2)	19	18.3	

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Sex of the Perpetrator



Sex of the Perpetrator

TABLE 2

Crime Against the Elderly

(May 1988 - May 1989)

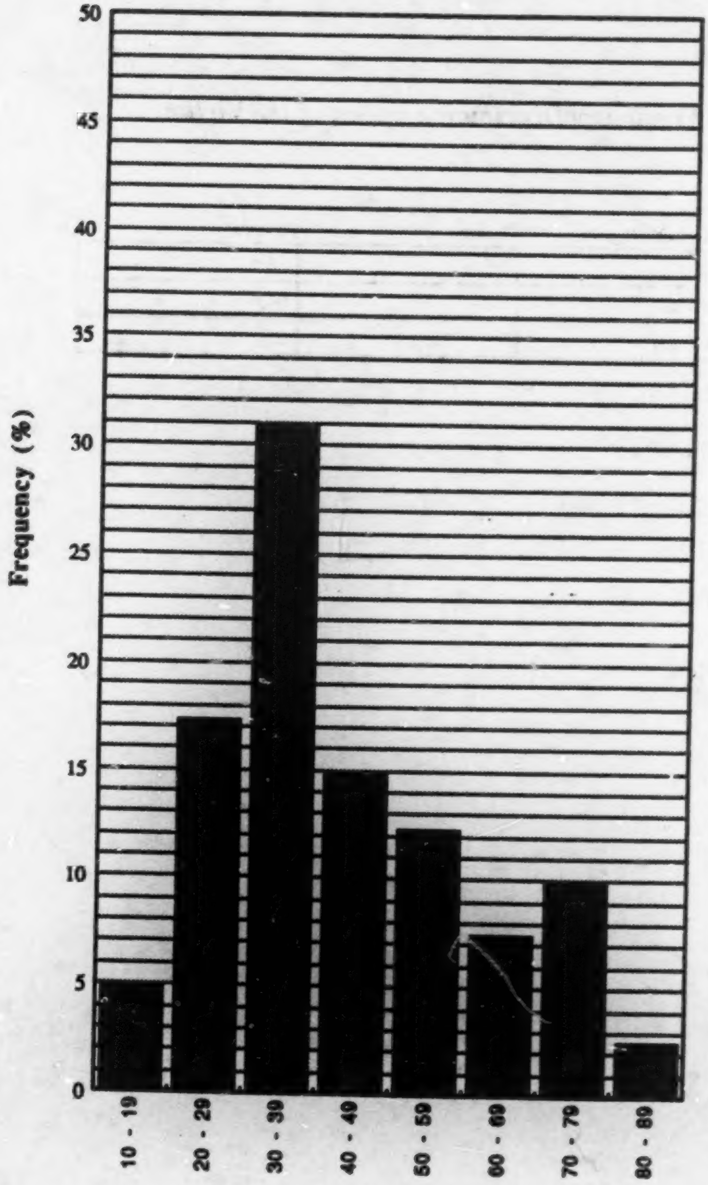
Frequency Distribution by Age of the Perpetrator

Bar:	From: (≥ yr)	To: (< yrs)	Count:	Percent:	
1	0	10	0	0	
2	10	20	4	4.9	
3	20	30	14	17.3	
4	30	40	25	30.9	- Mode
5	40	50	12	14.8	
6	50	60	10	12.3	
7	60	70	6	7.4	
8	70	80	8	9.9	
9	80	90	2	2.5	
10	90	100	0	0	

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Age of the Perpetrator



Age of the Perpetrator (years)

TABLE 3

Crime Against the Elderly
(May 1988 - May 1989)

Frequency Distribution by Sex of the Victim

Bar:	Sex of theVictim:	Count:	Percent:	
1	Male (1)	30	28.8	
2	Female (2)	67	64.4	- Mode
3	Both (3)	7	6.7	

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Sex of the Victim

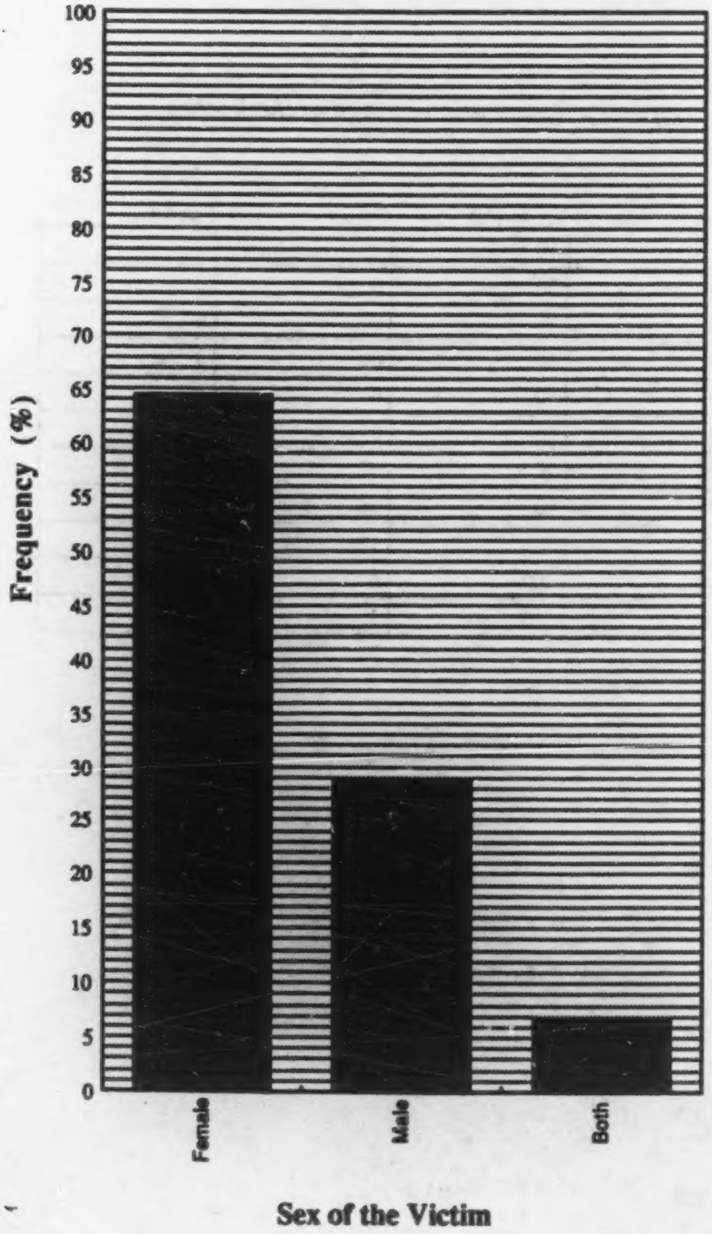


TABLE 4

Crime Against the Elderly

(May 1988 - May 1989)

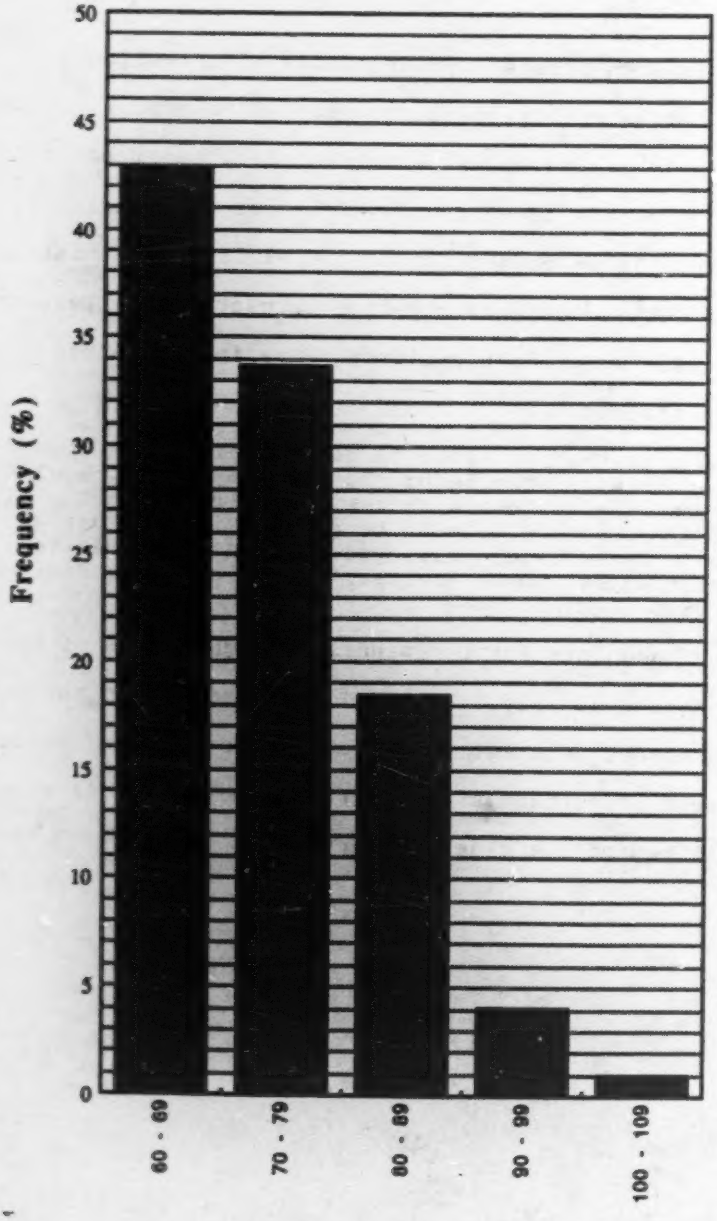
Frequency Distribution by Age of the Victim

Bar:	From: (≥ yrs)	To: (< yrs)	Count:	Percent:	
1	0	10	0	0	
2	10	20	0	0	
3	20	30	0	0	
4	30	40	0	0	
5	40	50	0	0	
6	50	60	0	0	
7	60	70	42	42.9	- Mode
8	70	80	33	33.7	
9	80	90	18	18.4	
10	90	100	4	4.1	
11	100	110	1	1	

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Age of the Victim



Age of the Victim (years)

known to their victims. Yet, over 30% (32.1%) of the perpetrators were children of the elderly (21.4% were sons, 10.7% were daughters), and a substantial proportion of the elderly women were abused by their male spouses (15.5%) (See Table 5).

There is much debate concerning the aforementioned findings. While earlier research studies painted a picture of abused elderly as individuals mistreated by their adult children, in a more recent study (Pillemer and Finklehor, 1988), a very large proportion of the elderly were mistreated by spouses (58%). Only twenty-five percent of the perpetrators in those cases were adult children. The investigators did admit that the key

> "dynamic is that an elder is most likely to be abused by the person with whom he or she lives. Many more elders live with their spouses than with their children. Since spouses are more likely to be present in an elderly person's household, their opportunities for abusive behavior appear to be greater." (Pillemer and Finklehor, 1988:55).

This fact accounts for the generally higher rate of spouse abuse among the elderly. However, the findings in the instant study are more consistent with the earlier research studies: the greatest percentage of non-stranger perpetrators were the adult children of the elderly victim.

TABLE 5

Crime Against the Elderly

(May 1988 - May 1989)

*Frequency Distribution by Relation of the Perpetrator to the Victim **

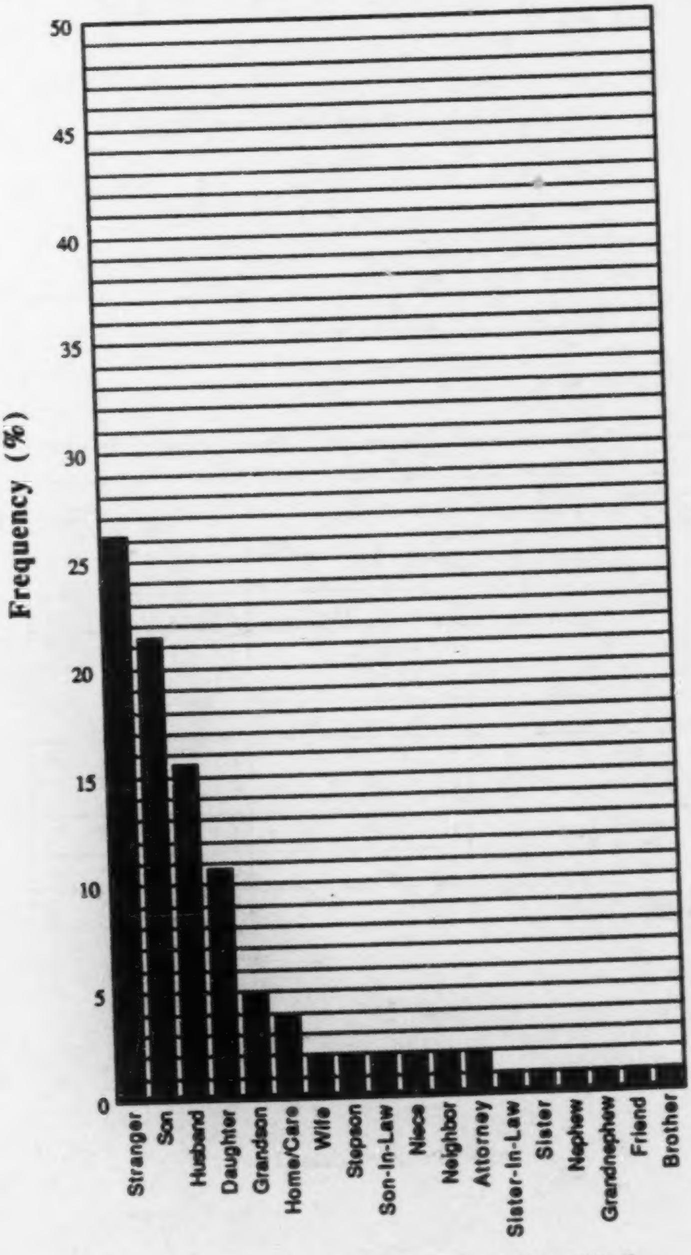
Bar:	Rel Perp to Victim:	Count:	Percent:	
1	Husband (1)	16	15.5	
2	Wife (2)	2	1.9	
3	Son (3)	22	21.4	
4	Daughter (4)	11	10.7	
5	Friend (5)	1	1	
6	Stranger (6)	27	26.2	- Mode
7	Son-In-Law (7)	2	1.9	
8	Stepson (8)	2	1.9	
9	Sister-In-Law (9)	1	1	
10	Home/Care (10)	4	3.9	
11	Neighbor (11)	2	1.9	
12	Grandson (12)	5	4.9	
13	Sister (13)	1	1	
14	Niece (14)	2	1.9	
15	Brother (15)	1	1	
16	Attorney (16)	2	1.9	
17	Grandnephew (17)	1	1	
18	Nephew (18)	1	1	

* excluding unknown data (1 case)

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Relation of the Perpetrator to the Victim



Relationship of the Perpetrator to the Victim

INCIDENT DATA

Research investigations have shown that with the exception of certain types of robbery, personal larceny, e.g., purse snatching and pocket-picking, and fraud, the elderly are less likely than younger persons to be the victims of crime (National Crime Survey 1980-1985). In the current study, harmful physical contact occurred in over 50% (55.8%) of the incidents (See Table 6). Economic crime, e.g., fraud, comprised 12.5% of the incidents in this sample, and property crime, e.g., felony theft, made up 7.7% of the criminal acts committed against the elderly victims in this cohort. More specifically, in the cases where a criminal complaint was issued (49% of the cases in this sample), some type of assaultive behavior was charged in over 50% of the complaints, while robbery and larceny offenses accounted for one-quarter of the crimes charged (See Table 7).

Physical force was used in over 50% of the incidents, and verbal mistreatment took place in over one-quarter of the abusive acts against the elderly (See Table 8)*

*Accurate information regarding the type of coercion used against the elderly victim was unobtainable in 3 cases.

TABLE 6

Crime Against the Elderly
(May 1988 - May 1989)

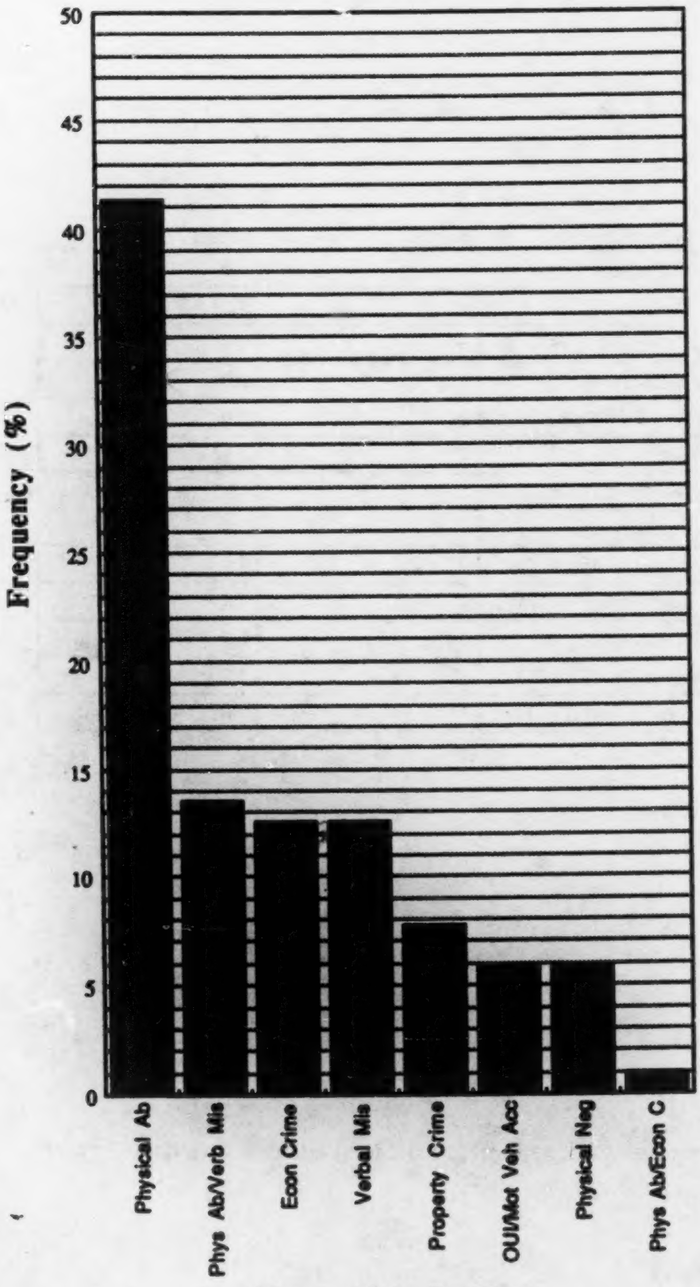
Frequency Distribution by Nature of the Incident

Bar:	Nature of the Incident:	Count:	Percent:	
1	Physical Ab (1)	43	41.3	- Mode
2	Physical Neg (2)	6	5.8	
3	Verbal Mis (3)	13	12.5	
4	Econ Crime (4)	13	12.5	
5	Phys Ab/Verb Mis (5)	14	13.5	
6	Phys Ab/Econ C (6)	1	1	
7	OUI/Mot Veh Acc (7)	6	5.8	
8	Property Crime (8)	8	7.7	
9	Unknown (9)	0	0	

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Nature of the Incident



Nature of the Incident

TABLE 7

Crime Against the Elderly

(May 1988 - May 1989)

*Frequency Distribution by Type of Offense **

Bar:	Type of Offense:	Count:	Percent:	
1	OUI/Car Acc (1)	3	5.9	
2	Assault (2)	19	37.3	- Mode
3	Felony/Theft (3)	5	9.8	
4	Burglary (4)	1	2.0	
5	Mal Dam Prop (5)	2	3.9	
6	Sexual Ass (6)	2	3.9	
7	Viol Rest Order (7)	7	13.7	
8	Robbery (8)	3	5.9	
9	Motor Veh Hom (9)	2	3.9	
10	Larc False Pre (10)	4	7.8	
11	Trespass (11)	1	2.0	
13	Attempted Mur (13)	1	2.0	
14	Lea Sc Inj/OTE (14)	1	2.0	

* excluding not applicable (51 cases) and unknown data (2 cases)

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Type of Offense

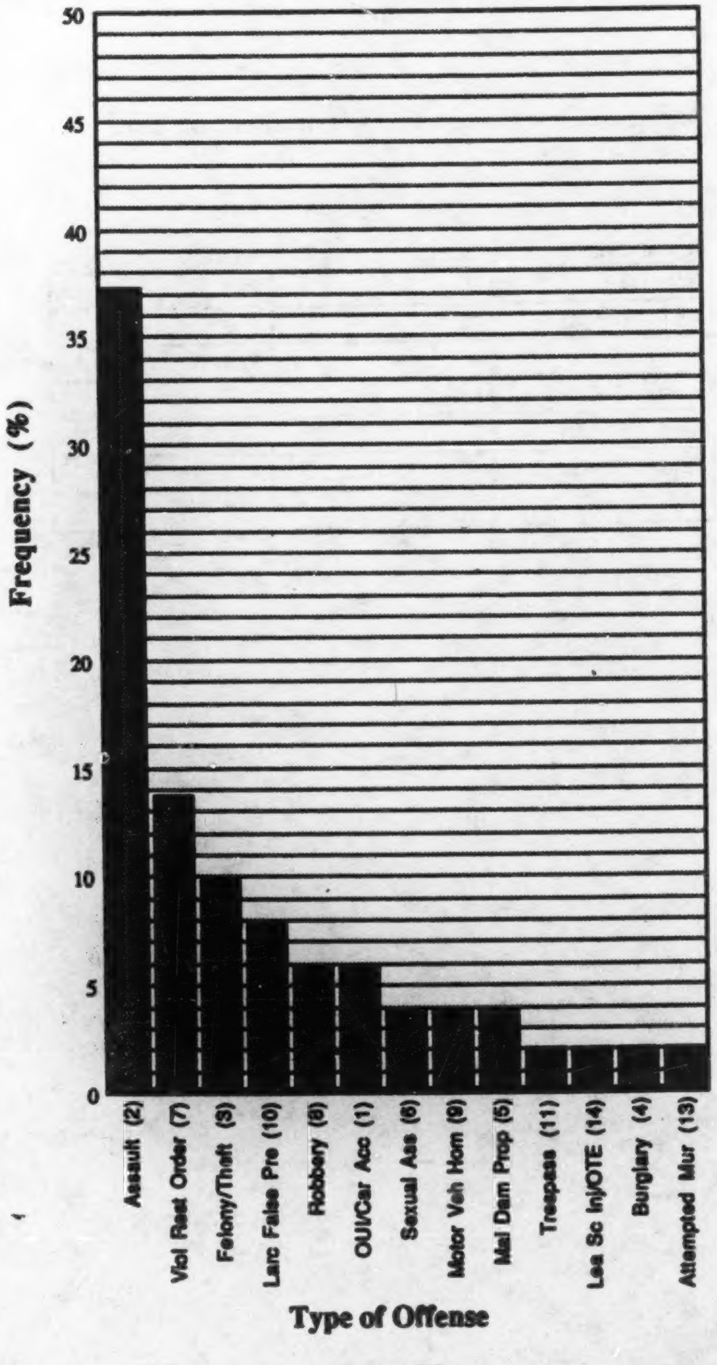


TABLE 8

Crime Against the Elderly

(May 1988 - May 1989)

*Frequency Distribution by Type of Coercion Used **

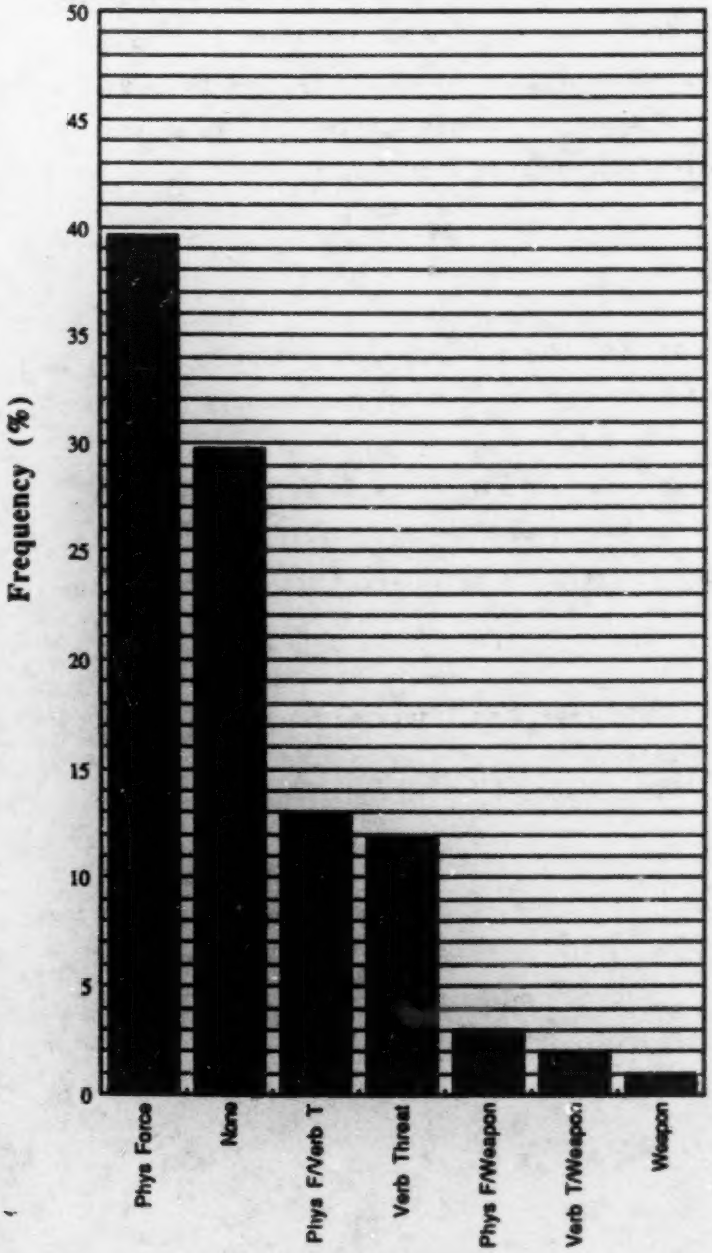
Bar:	Type of Coercion:	Count:	Percent:	
1	None (1)	30	29.7	
2	Verb Threat (2)	12	11.9	
3	Phys Force (3)	40	39.6	- Mode
4	Weapon (4)	1	1	
5	Verb T/Weapon (5)	2	2	
6	Phys F/Weapon (6)	3	3	
7	Phys F/Verb T (7)	13	12.9	

* excluding unknown data (3 cases)

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Type of Coercion Used



Type of Coercion Used

Finally, as a result of these abusive and/or criminal incidents, many elderly victims suffered from physical and/or emotional damage (See Table 9). More specifically, 35% of the elderly suffered from some form of emotional or psychological injury, while over 40% (43.3%) suffered some form of physical trauma ranging from minor (no physician required) to major (requiring hospitalization) physical injury (See Table 9). The data also reflect that two elderly victims died as a result of injuries incurred during these incidents.*

SENTENCE DATA

In this cohort of elderly victims, the majority of the cases (58%) did not enter the legal system through protective services (See Table 10).

As noted previously, in 49% of the cases in this sample, a criminal complaint was issued (See Table 11). In almost 35% (34.6%) of the incidents, the cases were closed. Some of the

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*Accurate information regarding injury to the victim was not available for 7 cases.

TABLE 9

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Injury to the Victim *

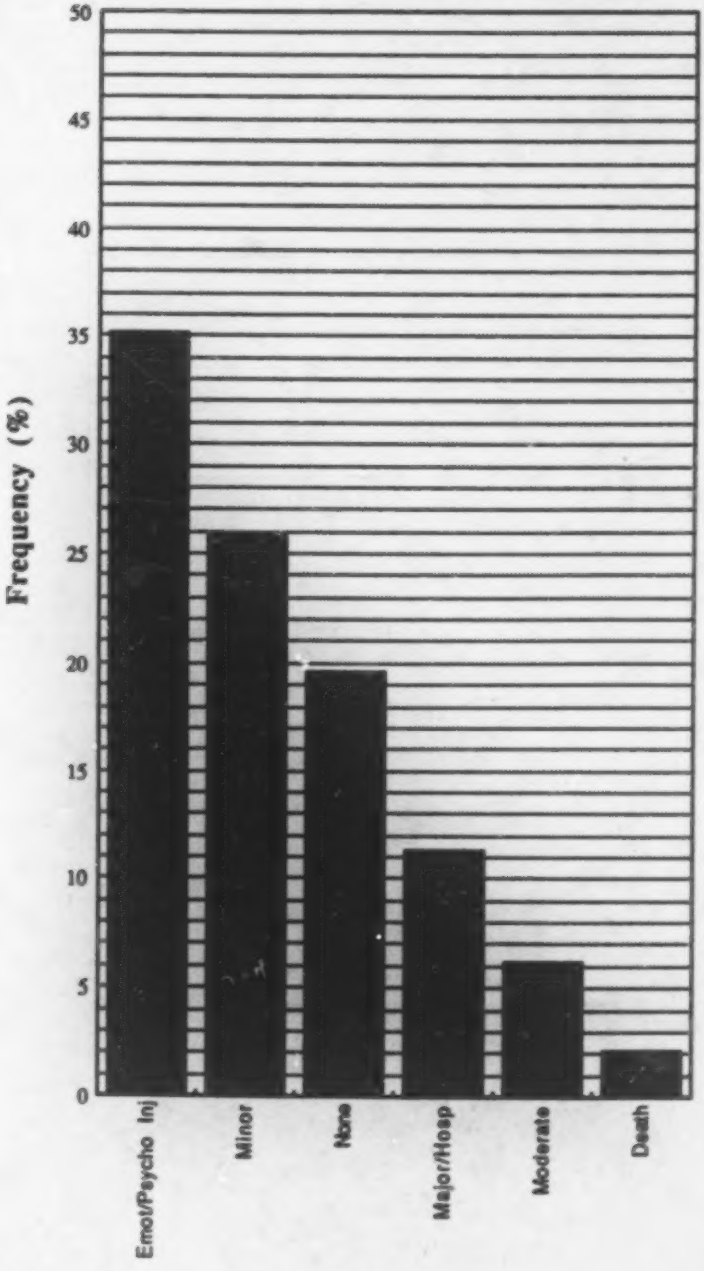
Bar:	Injury to Victim:	Count:	Percent:	
1	Minor (1)	25	25.8	
2	Moderate (2)	6	6.2	
3	Major/Hosp (3)	11	11.3	
4	Emot/Psycho Inj (4)	34	35.1	- Mode
5	None (5)	19	19.6	
6	Death (6)	2	2.1	

* excluding unknown data (7 cases)

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Injury to the Victim



Injury to Victim

TABLE 10

Crime Against the Elderly
(May 1988 - May 1989)

Frequency Distribution by Protective Services *

Bar:	Protective Services:	Count:	Percent:	
1	Yes (1)	43	41.7	
2	No (2)	60	58.3	- Mode

* excluding unknown data (1 cases)

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Protective Services

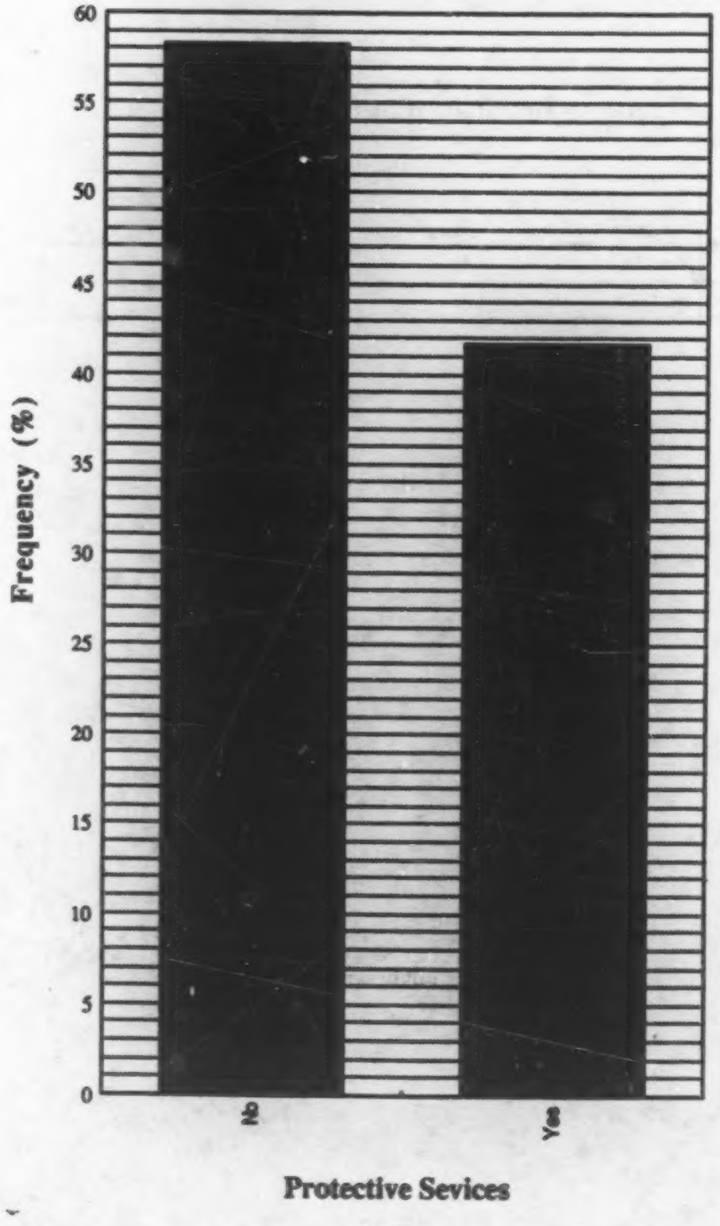


TABLE 11

Crime Against the Elderly
(May 1988 - May 1989)

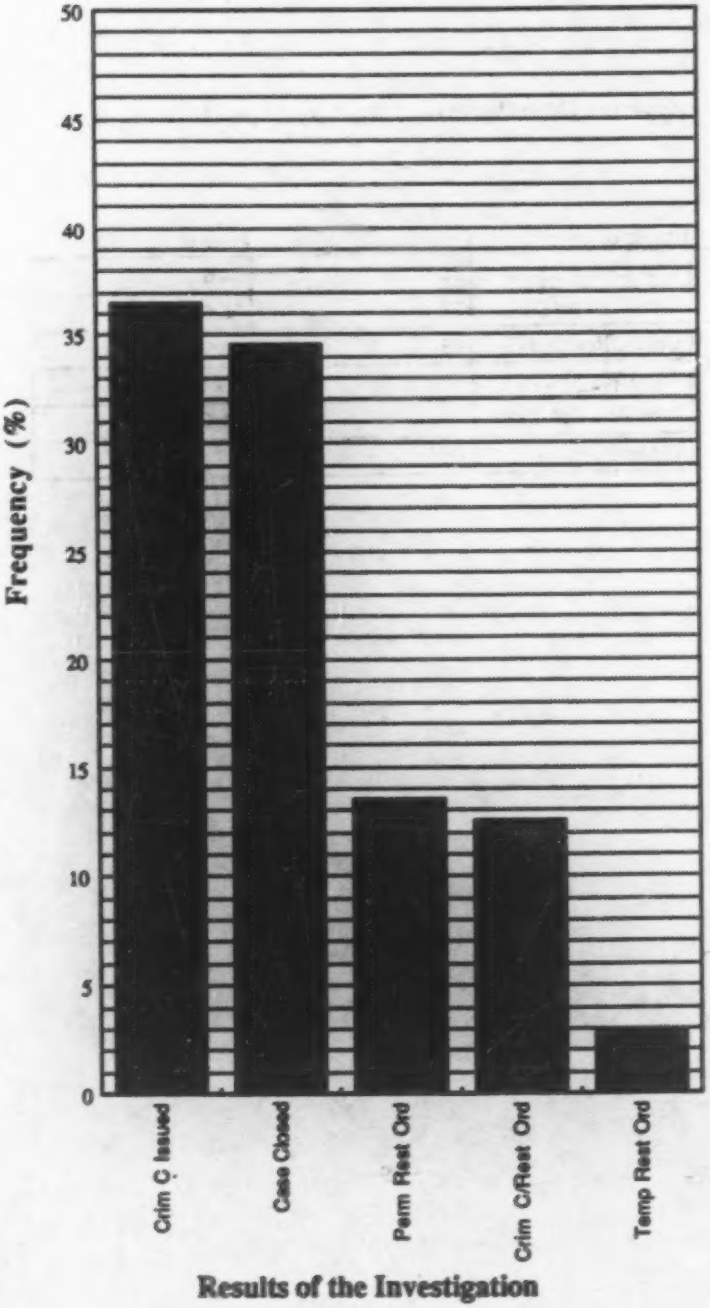
Frequency Distribution by Results of the Investigation

Bar:	Results of Invest:	Count:	Percent:	
1	Case Closed (1)	36	34.6	
2	Crim C Issued (2)	38	36.5	- Mode
3	Crim C/Rest Ord (3)	13	12.5	
4	Temp Rest Ord (4)	3	2.9	
5	Perm Rest Ord (5)	14	13.5	
9	Unknown (9)	0	0	

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Result of the Investigation



reasons underlying the latter result are the following: (1) lack of cooperation by the victim: (2) the victim was ill and could not possibly testify in court; (3) services were being provided to the victim by the Department of Elder Affairs; and (4) some cases warranted civil rather than criminal action. Lastly, in those cases in which a criminal complaint was issued, the majority of the perpetrators (62.7%) were convicted of their offense(s) (See Table 12). Of the smaller cohort of individuals who were convicted of their crimes, over half of the perpetrators (53.1%) were ordered to serve time in either a house of corrections or state prison. Approximately one-third of the convicted defendants received a suspended sentence, while one-eighth of the perpetrators were accorded a less restrictive sentence, e.g., probation.

CONCLUDING REMARKS

Although the sample size is relatively small (104 cases) and, as a result, generalizing to the larger population of perpetrators of crime against the elderly and their victims is difficult, this data set is unique in that it is the first systematic examination of cases of crime against the elderly in

TABLE 12

Crime Against the Elderly
(May 1988 - May 1989)

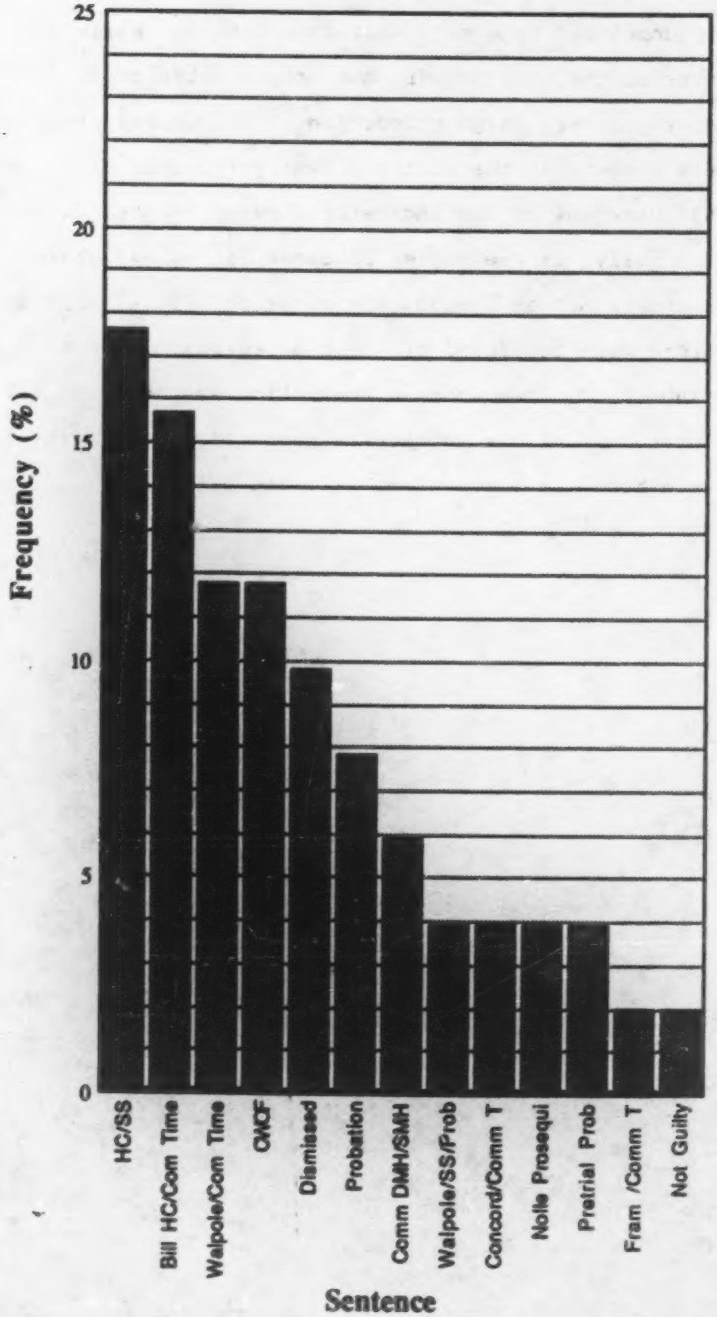
Frequency Distribution by Type of Sentence

Bar:	Type of Sentence:	Count:	Percent:	
1	Nolle Prosequi (1)	2	3.9	
2	Bill HC/Com Time (2)	8	15.7	
3	Walpole/Com Time (3)	6	11.8	
4	Dismissed (4)	5	9.8	
5	Comm DMH/SMH (5)	3	5.9	
6	Not Guilty (6)	1	2	
7	HC/SS (7)	9	17.6	- Mode
8	Concord/Comm T (8)	2	3.9	
9	Frame/Comm T (9)	1	2	
10	CWOF (10)	6	11.8	
11	Probation (11)	4	7.8	
12	Walpole/SS/Prob (12)	2	3.9	
13	Pretrial Prob (13)	2	3.9	

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Type of Sentence



Middlesex County, and possibly in Massachusetts. The results are indeed preliminary, and further research is imperative to truly substantiate this body of work. Yet, some interesting findings did emerge from this data set.

In this sample, the crimes against the elderly were generally committed by a male against a female. While over one-quarter of the victims were not known to their perpetrators, a very large proportion of the perpetrators (over 50%), were members of the victim's family (spouses or adult children). Over 50% of the incidents were of an assaultive nature. Finally, in the subset of cases (51 cases) where a criminal complaint was issued, the majority (62.7%) of the perpetrators were convicted of their offenses. In an even smaller subset of cases where a conviction was achieved (32 cases), over half of the defendants were ordered to serve time in either a house of corrections or state prison.

REFERENCES

REFERENCES

Goldsmith, Jack, "Criminal Victimization of Older Persons: Problems and Programs." Connecticut Law Review 9:435-449 (1977).

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Whitaker, Catherine J., "Elderly Victims" Bureau of Justice Statistics Special Report, November, 1987.

APPENDIX

Crime Against the Elderly
(May 1988 - May 1989)

Frequency Distribution by Court Location

Bar:	Court:	Count:	Percent:	
1	Cambridge (1)	36	34.6	-Mode
2	Lowell (2)	13	12.5	
3	Natick (3)	3	2.9	
4	Somerville (4)	12	11.5	
5	Camb Sup (5)	5	4.8	
6	Malden (6)	11	10.6	
7	Framingham (7)	7	6.7	
8	Lowell Sup (8)	0	0	
9	Waltham (9)	7	6.7	
10	Newton (10)	2	1.9	
11	Concord (11)	2	1.9	
12	Ayer (12)	1	1	
13	Marlboro (13)	3	2.9	
14	Woburn (14)	2	1.9	
15	Unknown (99)	0	0	

Crime Against the Elderly

(May 1988 - May 1989)

Frequency Distribution by Court Location

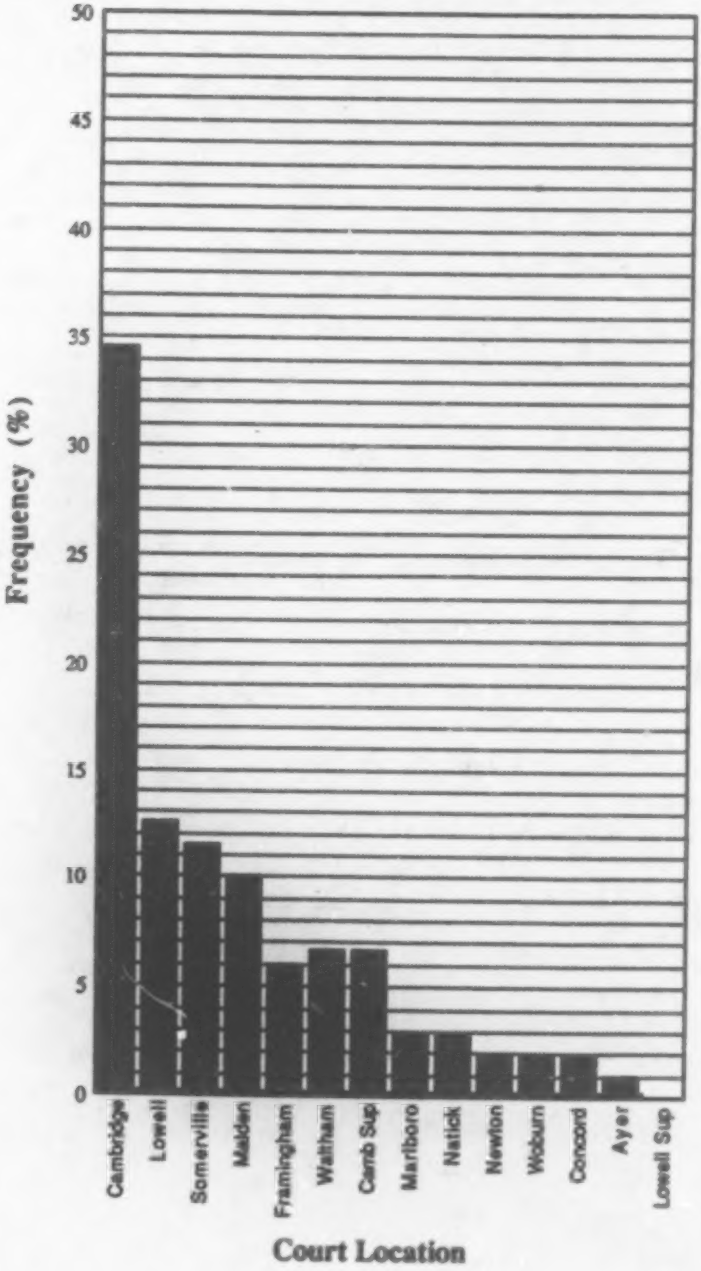

EXHIBIT A

ELDER ABUSE CASE ABSTRACT FORM

______________________ NAME OF PERPETRATOR	______________________ DATE CASE OPENED
______________________ NAME OF VICTIM	______________________ DATE CASE CLOSED OR DISPOSED OF
______________________ COURT	______________________ CASE NO.

DEMOGRAPHIC DATA

1. Sex of the perpetrator ______ MALE ______ FEMALE

2. Sex of the victim ______ MALE ______ FEMALE

3. Age of the perpetrator ______

4. Age of the victim ______

INCIDENT DATA

5. Nature of the incident:

______________ PHYSICAL ABUSE	______________ PHYSICAL NEGLECT	______________ VERBAL MISTREATMENT	______________ ECONOMIC CRIME (FRAUD)

6. Relationship of the perpetrator to the victim

____
(e.g., spouse, son, daughter, friend)

7. Type of coercion used in incident:

____
(e.g., verbal threat, physical force, weapon, none)

8. Injuries to the victim: ______________________
[e.g., minor, major (requiring hospitalization), emotional injury, psychological injury]

LEGAL DATA

9. Did the case enter the system through protective services?

______ YES ______ NO

10. Results of the investigation:

__________________ CASE CLOSED

__________________ CRIMINAL COMPLAINT ISSUED

__________________ CRIMINAL COMPLAINT AND RESTRAINING ORDER (209A)

__________________ RESTRAINING ORDER (209A)

11. If a criminal complaint was issued, what sentence was eventually imposed?

____

Commonwealth of Massachusetts
Executive Office of Elder Affairs

Elder Protective Services Program Report

Fiscal Year 1989

MICHAEL S. DUKAKIS
Governor

PAUL J. LANZIKOS
Secretary

ANDREW M. BADER
Assistant Secretary
for Program Management

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EXECUTIVE OFFICE OF ELDER AFFAIRS
ELDER PROTECTIVE SERVICES PROGRAM
FISCAL YEAR 1989

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The Commonwealth of Massachusetts
Executive Office of Elder Affairs
38 Chauncy Street, Boston, Mass. 02111

MICHAEL S. DUKAKIS
GOVERNOR

PAUL J. LANZIKOS
SECRETARY

Dear Friend,

Thousands of vulnerable, elderly victims of abuse and neglect live in fear every day in communities across the Commonwealth. Reports are on the rise. During the past six years, reports of elder abuse and neglect have more than doubled.

The Protective Service Program protects individuals who are at-risk of abuse, 60 years and older, and live in the community. Our program is one of the finest in the country. This year, we took some steps to make the program even stronger.

First, we initiated written program standards to better guide the work of protective service social workers. We also developed standard procedures for intake and improved our intake form. These steps will help us to collect valuable data statewide so that we can more effectively monitor incidents of abuse and neglect and ensure that our services respond to the diverse needs of elderly victims.

Second, we conducted statewide surveys to examine the problem of self-neglecting elders who are not included in the Protective Services Program. With the survey results, we will be able to determine the best way to respond to this serious problem. Third, we developed a video training library for protective services staff and expanded our outreach efforts in the community to increase our ability to educate professionals and the general public about elder abuse and neglect.

These improvements were only some of those effected this year and were made at a time of diminished resources and with a great deal of sensitivity and creativity by protective service staff members.

While we are proud of our accomplishments, there is much to be done. I look forward to working with you in the future as we strive to protect some of our most vulnerable citizens from harm.

Sincerely,

Paul J Lanzikos

Paul J. Lanzikos

TABLE OF CONTENTS

Executive Summary 1

Elder Protective Services Program 4

- Organization 4
- Implementation 6

FY '89 Accomplishments 19

- Protective Services Agencies 19
- Special Projects 25

FY '90 Initiatives 40

Appendices

Appendix A. Chapters 604 and 566 Combined: An Act Providing Protection for Elderly Persons. Chapter 19A, Sections 14 to 26.

Appendix B. 651 CMR 5.00 Regulations Governing The Elder Abuse Reporting and Protective Services Program.

Appendix C. Intake Standards of Practice

Appendix D. Revised Elder Abuse Intake Form

Appendix E. Index of Designated Protective Services Agencies.

Appendix F. Index of Guardianship Contractor Agencies.

Making a Difference in the Lives of Abused Elders

Throughout this report, case examples are given which are representative of elders in whose lives Protective Services has made a difference. Elders are not always willing to accept help; many choose to live under difficult and painful conditions. However, the many success stories we hear about at Elder Affairs remind us that we are not only serving a certain population described in our statistics, but are making a crucial difference in the lives of individual elders who would otherwise suffer needlessly without Protective Services intervention.

Personal identifiers have been changed to protect client confidentiality.

Executive Summary

The Elder Protective Services Program, mandated by the Protective Services Statute (M.G.L., Chapter 19A. s. 14-26), is responsible for providing services to abused and neglected elders of the Commonwealth, aged 60 and over. Elder abuse is defined as "an act or omission which results in serious physical or emotional injury to an elderly person." Abuse includes physical battering and emotional maltreatment. Neglect includes the deprivation of necessities. Since July 1983, when the law took effect, reports of abuse or neglect have increased from 1,529 in FY '84 to 3,094 reports in FY '89. This is an increase of 102%, or a doubling of the number of reports received within six (6) years.

During FY '89, cases of abuse and neglect increased 12 percent. Most of this increase occurred in the eastern portion of Massachusetts.

The Protective Services Program is administered by the Executive Office of Elder Affairs, Office of Program Management. The Unit normally includes a Protective Services Director, five Regional Supervisors and a Program Specialist. Each Regional Supervisor is responsible for the Protective Services Agencies clustered in one geographical area of the state: North, South, Greater Boston, Central and West. The Program Specialist has responsibility for management of the Protective Services contracts which deal with Elders at Risk, Guardianship and the 24-hour Elder Abuse Hotline. During FY '89, four Regional Supervisors were responsible for five (5) Regions, and the Elder At Risk, Homeless, Guardianship and Hotline Programs. The Program Specialist and Southern Regional Supervisor positions were not filled due to state management staff reductions.

Protective Services Delivery is provided by twenty-six Home Care Corporations and one Community Mental Health Center which have been designated by the Executive Office of Elder Affairs as Protective Services Agencies. Each designated agency is required to: receive and screen reports of abuse and neglect, conduct an assessment and functional evaluation and provide or arrange for Protective Services. Services provided may be casework, homemaker, home-health aides, transportation, legal assistance, nutrition or other services necessary to alleviate the abuse or neglect.

The Elder Abuse Hotline operates 24-hours-a-day, 7-days-a-week to receive reports of abuse or neglect. Each designated Protective Services Agency has on-call staff to respond to emergency situations which occur after business hours. Elder Affairs staff can also be contacted through the Hotline for emergency consultation on a 24-hour basis.

The Protective Services Program provides casework/counseling services to vulnerable elders through contracts with community agencies in Boston and Worcester under the Elder At Risk Program. These agencies intervene to offer services to elders who are not abused or neglected but who are "at risk" due to other factors which effect their ability to remain safely in the community.

The Guardianship Program serves elders who have been abused or neglected. The Executive Office of Elder Affairs contracts with seven (7) private, non-profit social services agencies to provide guardianship and conservatorship services to elders who are at risk of injury, are incompetent and who have no other resources available to them.

The Executive Office of Elder Affairs maintains a strong commitment to abused and neglected elders of the Commonwealth, and continues to explore innovative and more cost effective ways to better serve this population.

In response to concerns about the growing number of "at risk" elders identified across the Commonwealth who are not appropriate for Protective Services, two statewide surveys were conducted in conjunction with Massachusetts Home Care Association. Information from 130 responding agencies indicated a need for a statewide Elder At Risk program. The surveys, and program audits of existing Elder At Risk Programs, revealed a need for targeting the most vulnerable elders, and to expand services, state wide, using existing program funds allocated to the Elder At Risk Program. In effect, monies would be focused on the Commonwealth's most needy elders. A Request for Proposals was developed for issuance and plans made to begin a state-wide Elder At Risk Program in FY '90.

During FY '89, in response to the passage of Chapter 566 legislation, Protective Services Regulations were changed to reflect statutory amendments. Statewide training was conducted for Protective Services Agencies.

Linkages with other State agencies were initiated. The Executive Office of Elder Affairs met with the Department of Mental Retardation to address the specialized needs of abused, mentally retarded elders in the community. Meetings were also initiated with the Department of Mental Health to clarify the handling of cases of abuse or neglect of elderly mental health clients. The Executive Office of Elder Affairs and the Disabled Persons Protection Commission joined together to contract for state-wide hotline services. This resulted in a savings of $40,000 for Elder Affairs.

Standards of practice for the receipt and handling of reports of abuse and neglect were developed and disseminated to the field in conjunction with a revision of the Elder Abuse Intake Form. Implementation of the Intake form is planned for FY '90.

Other program initiatives during FY '89 included the establishment of a state-wide Protective Services videotape, training library; issuance of a protocol clarifying reporting to District Attorneys; development of a program instruction to clarify what situations constitute cases of neglect; issuance of guidelines for improved guardianship program monitoring; allowance for purchasing interpreting services to conduct assessments of abuse with non-English speaking elders; issuance of guidelines to clarify how long guardianship cases may be kept open after the death of wards; issuance of revised procedures for accessing emergency services; and the development of improved procedures for gathering guardianship program statistics.

Elder Protective Services Program

ORGANIZATION

The Executive Office of Elder Affairs' Protective Services Program includes the following components which are administered or monitored by Elder Affairs.

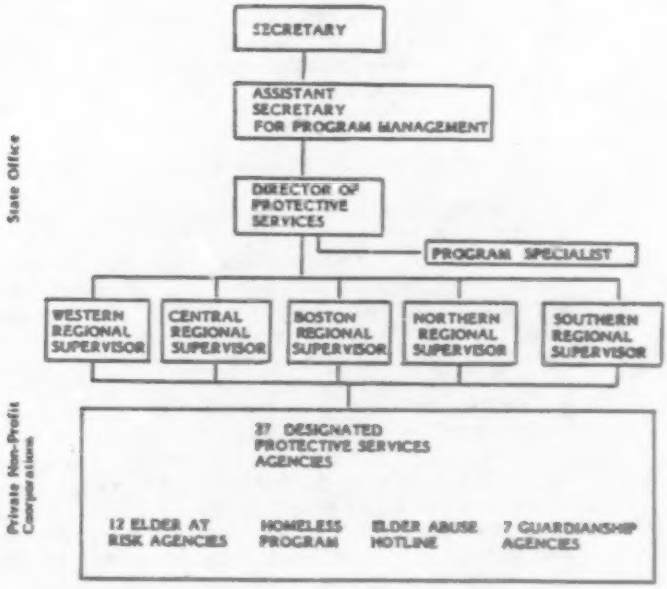
Protective Services Unit	Attached to the Executive Office of Elder Affairs Office of Programs is the Protective Services Director, five Regional Supervisors and a Program Specialist. One Regional Supervisor and the Program Specialist position have been vacant since 1988.
Designated Protective Services Agencies	The Executive Office of Elder Affairs has designated twenty-seven (27), private, non-profit agencies to serve as Protective Services Agencies. All but one are Home Care Corporations (see Appendix E).
Statewide Elder Abuse Hotline	This component is operated under contract with a private, non-profit social service agency. It operates on a 24-hour-a-day, 7-day-a-week basis.
Elder At Risk Program	This component currently provides casework/counseling services, which are available in Boston and Worcester for elders who do not fall under the Elder Protective Services Statute, but who are at risk of injury due to other factors which effect their ability to remain safely in the community.
Guardianship Services	These services are for a limited number of elders who need guardianship to prevent abuse or neglect. For a list of Guardianship Contractor Agencies, please see Appendix F.

Homeless Elders Project	This is a specialized program for homeless elders in Boston. The Project provides housing search assistance, arranges for health and social services, assistance with personal care needs and information and referral services.

The Protective Services Unit reports directly to the Assistant Secretary for Program Management. Staff from the Executive Office of Elder Affairs has been assigned to each of the five regions within the Commonwealth. In addition to developing statewide programs and policies, Regional Supervisors provide program monitoring and evaluation, and clinical support and consultation. Elder Affairs staff is also responsible for establishing regulations and casework standards and ensuring the implementation of these in the field.

The Elder Protective Services Program operates in twenty-seven (27) Protective Services areas which are congruent with the Executive Office of Elder Affairs' Home Care services catchment areas.

EOEA PROTECTIVE SERVICES


SECRETARY
ASSISTANT SECRETARY FOR PROGRAM MANAGEMENT
State Office
DIRECTOR OF PROTECTIVE SERVICES
PROGRAM SPECIALIST
WESTERN REGIONAL SUPERVISOR
CENTRAL REGIONAL SUPERVISOR
BOSTON REGIONAL SUPERVISOR
NORTHERN REGIONAL SUPERVISOR
SOUTHERN REGIONAL SUPERVISOR
Private Non-Profit Corporations
27 DESIGNATED PROTECTIVE SERVICES AGENCIES
12 ELDER AT RISK AGENCIES
HOMELESS PROGRAM
ELDER ABUSE HOTLINE
7 GUARDIANSHIP AGENCIES

IMPLEMENTATION

The structure of the Elder Protective Services Program allows the sharing of responsibilities between the Executive Office of Elder Affairs and the designated agencies. The roles of Elder Affairs and the Protective Services Agencies, and the activities involved in meeting these responsibilities, are discussed below.

Designated Protective Services Agencies

Designated Protective Services Agencies have the responsibility for delivering Protective Services at the local level. Their major responsibilities and program objectives are:

- **Employment of Protective Caseworkers**

At the end of FY '89, there were over 60 full-time equivalent caseworker positions. Although the Executive Office of Elder Affairs established a standard job description and professional qualifications for Protective Caseworkers, they are not employees of Elder Affairs. Rather, they are employees of their respective Protective Services Agencies. The Protective Services Agency maintains qualification standards, supervises the work of caseworkers and provides on-going training to staff.

- **Provision of Protective Services**

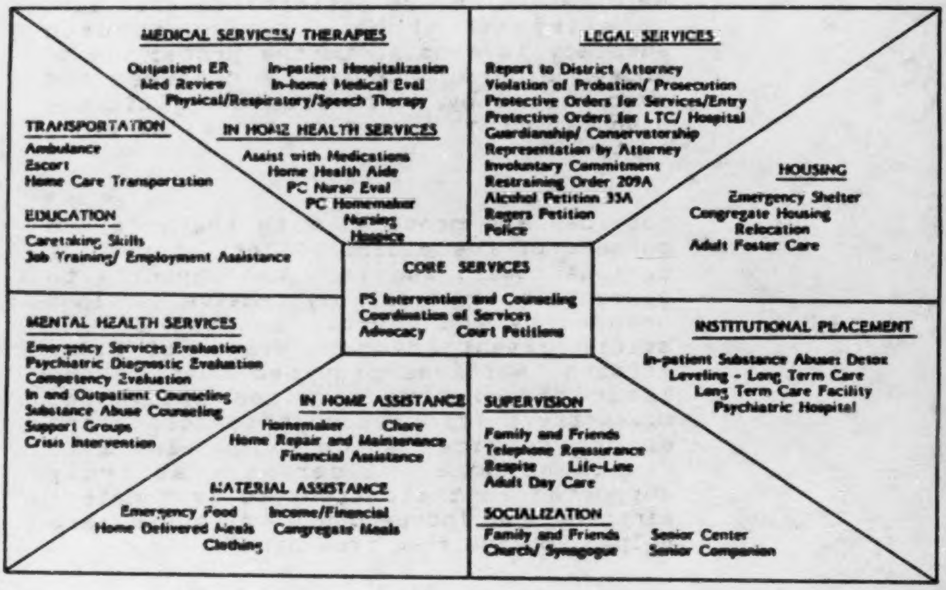
A report of elder abuse can be received from mandated reporters such as, physicians, police and social workers, from family and friends or from an abused elder. These reports are received by either the 24-hour Elder Abuse Hotline, or by the Protective Services Agency. Each report is screened to determine if an emergency exists and if the report warrants an Assessment under M.G.L., Chapter 19A, s. 14-26. Many cases that are "screened out" as not being "reportable abuse" cases are, in fact, channeled into the regular Home Care services process and may receive services through the state Home Care Program.

Protective Services Caseworkers have primary responsibility for conducting Assessments to determine whether abuse has occurred and to complete Functional Evaluations of elders to determine their mental, physical, social functioning and service needs. Caseworkers then develop Service Plans and provide or arrange for services which are designed to alleviate or eliminate abuse. Client-focused advocacy is crucial to the protection of abused elders, who may be confused and overwhelmed by difficult living circumstances and by a complex social services system.

Services are provided with the informed consent of the elder. Elders at risk of serious abuse, who lack the capacity to consent to services, may receive services ordered by the court. Because of the strong client advocate stance of Elder Affairs, services provided must be the least restrictive services available. Caseworkers first attempt to locate and secure services which allow elders to remain at home. Elders are actively supported in their right to self determination and independence while they are helped to live free from harm.

Mrs. K., age 67, was fearful that her husband, a well-respected businessman in their community, would kill her, should she accept Protective Services assistance. On several occasions, she arrived at the Mental Health Day Program with bruised arms, face and swollen lip. A report was filed, and the Protective Services Caseworker spoke with Mrs. K. who consistently refused to allow the Caseworker to speak to her husband. On two occasions reports were made, assessments conducted and the case closed, due to Mrs. K's. refusal of assistance. Reports were also made to the District Attorney. Mrs. K. was noted to be competent and able to choose not to have Protective Services intervention. A third report was received that Mrs. K. sustained welts across both her legs when Mr. K. struck her with a belt. On this occasion, probably in relation to worsening abuse and a relationship formed with the Caseworker, Mrs. K. accepted assistance. The Protective Caseworker met with the husband, indicated another report to the District Attorney was being filed and eventually convinced him of the need for counseling. Through counseling and fear of prosecution, Mr. K. has stopped physically abusing his wife.

Services which may be arranged or provided by the Protective Services agency are:


MEDICAL SERVICES/ THERAPIES
Outpatient ER
In-patient Hospitalization
Med Review
In-home Medical Eval
Physical/Respiratory/Speech Therapy
TRANSPORTATION
Ambulance
Escort
Home Care Transportation
IN HOME HEALTH SERVICES
Assist with Medications
Home Health Aide
PC Nurse Eval
PC Homemaker
Nursing
Hospice
EDUCATION
Caretaking Skills
Job Training/ Employment Assistance
LEGAL SERVICES
Report to District Attorney
Violation of Probation/ Prosecution
Protective Orders for Services/Entry
Protective Orders for LTC/ Hospital
Guardianship/ Conservatorship
Representation by Attorney
Involuntary Commitment
Restraining Order 209A
Alcohol Petition 35A
Rogers Petition
Police
HOUSING
Emergency Shelter
Congregate Housing
Relocation
Adult Foster Care
CORE SERVICES
PS Intervention and Counseling
Coordination of Services
Advocacy
Court Petitions
MENTAL HEALTH SERVICES
Emergency Services Evaluation
Psychiatric Diagnostic Evaluation
Competency Evaluation
In and Outpatient Counseling
Substance Abuse Counseling
Support Groups
Crisis Intervention
INSTITUTIONAL PLACEMENT
In-patient Substance Abuse: Detox
Leveling - Long Term Care
Long Term Care Facility
Psychiatric Hospital
IN HOME ASSISTANCE
Homemaker
Chore
Home Repair and Maintenance
Financial Assistance
SUPERVISION
Family and Friends
Telephone Reassurance
Respite
Life-Line
Adult Day Care
MATERIAL ASSISTANCE
Emergency Food
Income/Financial
Home Delivered Meals
Congregate Meals
Clothing
SOCIALIZATION
Family and Friends
Senior Center
Church/ Synagogue
Senior Companion

Protective Services are terminated either when the abuse/neglect is alleviated, or when the elder makes the informed choice of refusing further Protective Services. When Protective Services end, clients may, if appropriate, continue to receive Home Care services.

•Legal Intervention

Reporting Serious Abuse and Death to District Attorneys

Massachusetts General Laws, Chapter 19A, Sections 14 to 26 (see Appendix A), mandates the reporting of serious abuse and abuse-related deaths to District Attorneys. Standardized procedures and reporting forms are used for reports to the District Attorney. Once a report is filed, the District Attorney's office makes a determination, regarding legal action, while the Protective Services Worker continues to offer services to protect the elder.

Mrs. D., age 75, was admitted to a hospital where she nearly died from hemorrhaging due to sexual assault. Mrs. D's. son brought her to the hospital where it was discovered she had sustained severe vaginal tearing into her bladder from assault with a flashlight. She required skin grafts for external pelvic bruising related to the internal injuries. Following recovery from intensive care, Mrs. D. consistently denied being assaulted by her son, claiming she had inflicted this injury upon herself. Although periodically delusional, Mrs. D. was found to be competent. She refused assistance with protection from her son. The Protective Services Caseworker filed a report with the District Attorney based on conversations with the son where he appeared obsessed with talking about cleaning the bloodied flashlight and observations by the attending physicians that it was physically impossible for Mrs. D. to have inflicted this injury on herself, prior to losing consciousness. In response to this report to the D.A., a state police investigation was initiated. While a number of attempts were made to obtain a statement by Mrs. D. that assault did occur, these were unsuccessful. Although the Protective Services and the District Attorney's office coordinated their efforts closely, not enough evidence could be found to prosecute without Mrs. D's. testimony. Mrs. D. refused Protective Services, and court action, but has agreed to nursing home placement. The District Attorney is keeping this case open as a deterent to the son convincing his mother to leave the nursing home and return home.

Protective Orders

Protective Orders, through the probate court system, may be used in situations when an abused or neglected, elderly person lacks the capacity to consent to Protective Services. In such circumstances, sections 20(a) & (b) of M.G.L. Chapter 19A enable designated Protective Services Agencies to petition the probate court for a finding regarding the elder's capacity to consent.

The court may then issue an order for the provision of Protective Services which utilizes alternatives that are the least restrictive to the elderly person. The Elder Affairs Protective Services Regulations provide procedures for both emergency and non-emergency Protective Orders.

Guardianship Petitions

With a limited Guardianship Program to serve elders at risk of injury and who are in need of a conservator or guardian, Protective Services Agencies may petition the courts for an appointment of legal fiduciary when this is the least restrictive alternative remaining to provide for the protection of elders, lacking the capacity to consent to services.

Mrs. M., age 71, has been able to remain in the community for over six years with the help of a Conservator. Mrs. M. had decided not to pay rent due to a delusion that her deceased husband was in the Navy and was paying her rent. Mrs. M. had been in and out of state hospitals and had been diagnosed as paranoid schizophrenic. She was facing eviction and placement in long-term care after eleven months of non-payment of rent. A daughter, who had been handling her other bills became frustrated with her mother's behavior and withdrew her support. Mrs. M. had also been hitting neighbors with her cane and collecting and saving junk and rubbish which became a fire hazard. Because Mrs. M. was putting herself at risk, she received a Conservator. When Mrs. M. required a hip replacement and it was determined that she was unable to make medical decisions, a guardianship was obtained through the Protective Services Guardianship Program. The Guardian was able, over several years, to work with Mrs. M.'s neighbors to help them learn how to respond to her behavior, pay rent due, and was able to convince Mrs. M. to part with the newspapers and rubbish in her apartment. Although the apartment consists of narrow pathways between rooms piled full of furniture and other belongings, the hazard from fire has diminished. Mrs. M. now enjoys the visits of her Caseworker, who has also established a bank account for Mrs. M. with monies left after paying bills to insure her protection, and has convinced Mrs. M. to accept the services of a Personal Care Homemaker and Meals on Wheels. Mrs. M. attends church and takes a bus to go shopping. In addition to protecting Mrs. M's right to independence, it is estimated that the state has saved over $196,000 to date, or about $32,000 per year, due to the successful efforts of the Guardian to maintain Mrs. M. at home rather than in a nursing home or DMH facility.

- **Community Education**

Protective Services Agencies have the responsibility for informing other professionals in the community of the mandatory reporting law and procedures.

Protective Services Agencies provide extensive training and community outreach to ensure that professionals have current information on Elder Protective Services.

Training sessions have been provided for hospitals, Visiting Nurse/Home Health Associations, Police Departments, Mental Health Centers, Senior Centers, Councils on Aging and other Social Service organizations. Training and community education are important in order to maintain awareness of Elder Protective Services as well as to develop links with community agencies which also serve elders.

The EOEA Protective Services Unit

The Executive Office of Elder Affairs has the responsibility for coordinating the effective and efficient delivery of Protective Services on a statewide basis. The major activities and program responsibilities of Elder Affairs are:

- **Program Monitoring**

Through the four Regional Supervisors, each designated Protective Services, Guardianship, Elder At Risk and Hotline Agency is monitored for adherence to Elder Affairs Protective Services Regulations (651 CMR 5.00), Program Instructions and quality of service provision.

- **Clinical Consultation and Training**

The Protective Services Director and the Regional Supervisors are available to all designated agencies on a 24-hour basis for clinical consultation on difficult, abuse cases and in emergency situations.

Training on clinical and regulatory issues occurs on a regular basis both through monthly regional meetings and periodic seminars.

- **Program and Policy Development**

The Protective Services Director and Regional Supervisors have responsibility for ongoing reassessment of current policy and practice, development of program modifications and creating new program initiatives to better meet the needs of abused elders in Massachusetts.

- **Data Collection**

The Executive Office of Elder Affairs collects monthly statistics from each designated agency regarding the number and types of reports received, the results of assessments conducted, and the number of cases opened and closed during each month. These statistics are aggregated on both a regional and statewide basis.

- **Community Education**

Community education is the primary means of increasing public awareness of elder abuse. Elder Affairs provides general information regarding elder abuse and specific information regarding reporting requirements and procedures to the general public. In addition, Office of Elder Affairs staff has presented to local and national conferences, to community groups and to professional organizations.

The Regional Supervisors also work with each designated Protective Services Agency to ensure that mandated reporters in each area are knowledgeable about reporting and available services.

Statewide Elder Abuse Hotline

The Protective Services Statute mandates the Executive Office of Elder Affairs to establish a mechanism for the receipt of reports on a 24-hour-per-day basis. Further, it requires designated Protective Services Agencies to have the capacity to respond to an emergency and to arrange for services to alleviate the danger of abuse to an elder on a 24-hour-per-day basis.

The Elder Abuse Hotline operates 24-hours-a-day, 365-days-a-year to receive reports of elder abuse or neglect as well as to provide information and referral services to elders. Each Designated Protective Services Agency is required to have one staff person, on call by pager, after business hours and to have administrative back up available.

If the staff of the Elder Abuse Hotline determines that an immediate emergency response is necessary, the Hotline pages the local Caseworker. That designated agency staff person then responds in order to alleviate the risk to the elder.

The Executive Office of Elder Affairs also maintains after-hours coverage for emergency Protective Services situations. Each night and on weekends, one Regional Supervisor carries a pager in order to be available for consultation. The Protective Services Director also carries a pager and serves as administrative back-up. The toll-free number in Massachusetts is (800) 922-2275.

The Elder Abuse Hotline was called on a Saturday morning by a Homemaker who found a bloodied wall where Mr. C. had fallen and hit his head. Mr. C. was confused and refused to seek medical attention stating that he had not eaten for several days. The Hotline paged the local On-call Worker who went to Mr. C's. home. It was learned that Mr. C. had neglected to care for his elderly sister, who was hospitalized for malnourishment after falling and lying on the floor for several days. Once she was gone, Mr. C. was unable to prepare meals for himself and had likely fallen due to a loss of equilibrium brought about by not eating and becoming intoxicated. Through the persistent efforts of the On-call Caseworker and police, Mr. C. was convinced to go to the hospital for treatment.

Guardianship and Conservatorship Program

The statewide Guardianship/ Conservatorship Program operates as a component of the Elder Protective Services Program and is intended to serve abused and neglected elders as defined by M.G.L., Chapter 19A, s 14-26.

Elder Affairs contracts with five (5) family service and two (2) mental health agencies to provide guardianship, limited guardianship, conservatorship and representative payee services to elders deemed incompetent by the court and at risk of injury.

The primary objective is to act as an adjunct to Protective Services, when no other less restrictive means are available to protect elders who are lacking the capacity to consent to services.

This is a program of last resort and, therefore, admission is stringently monitored. This is for two reasons. The primary reason is because guardianship and conservatorship are protections utilized only in extreme situations when all less restrictive alternatives to ensure an elder's safety have been exhausted. The second reason for careful screening is because of the relatively small number of available slots that must be reserved for the worst situations.

The referral process is multitiered. First, the case is screened at the level of the designated agency by the worker and supervisor. It is then screened by a Regional Protective Services Supervisor. At this point, it is very common for cases to be refused access - due to inappropriateness or because there are alternatives still to be explored. A final decision on difficult cases may be reached through consultation with the Protective Services Director and a staff attorney.

The criteria for admission are:

1. No other appropriate person
2. Few financial resources, or resources are not accessible
3. Lack of guardianship could result in serious injury, exploitation or death of the elder
4. All other alternatives have been explored
5. Medical certificate of incompetency.

Guardianship agencies provide all services necessary to carry out the orders of the court and to meet the needs of the elder. These include financial management, arranging for services, social casework and management of personal affairs.

It was reported that Mrs. C., a severely demented, elderly woman living by herself, was leaving her home in the middle of the night and becoming lost. On several occasions, the police found Mrs. C. and took her to her daughter's house. Mrs. C. was also unable to handle her own finances, and bills were not being paid. Mrs. C's. daughter attempted to assist with administering medications, and getting her to Elder Day Care; however, Mrs. C. was at risk of injury because of her inability to find her way home. The daughter, Mrs. W., was overwhelmed with the care of her own family and mother, and was hesitant to take responsibility to insure her mother's safety by obtaining guardianship and placing Mrs. C. in a nursing home. The Protective Services Caseworker was able to convince Mrs. W. to become her mother's guardian only by offering the assistance of the Protective Services Agency in petitioning the court for guardianship and the local Guardianship Agency to provide short-term casework assistance for six (6) months. After Mrs. W. was named her mother's temporary guardian, the Guardianship Caseworker assisted her in setting up a financial plan and burial account, preparing a court inventory of assets, intervening with Medicaid to pay overdue hospital bills, obtaining fuel assistance to pay gas bills, establishing Mrs. W. as Representative Payee for Mrs. C., and placing Mrs. C. in a nearby nursing home where she is now safe from injury. The provision of short-term assistance helped the daughter become guardian, rather than an agency funded by the Commonwealth.

In monitoring these agencies, the Executive Office of Elder Affairs places primary emphasis on how well the agency is ensuring the elder's safety. Safety is to be ensured by implementing the least restrictive means while involving the elder in the decision making process as much as possible. The major goals of this program are:

1. To protect the non-competent elder from harm and exploitation, and
2. To preserve, as much as possible, the non-competent elder's rights to self determination and dignity.

Guardianship contracts include the provision of time-limited, casework assistance to families as a way of helping families take responsibility in providing care for their elders while reducing costs to the state in caring for abused, incompetent elders. Currently there is the capacity to serve 115 elders.

Elder At Risk Program

Since 1985, the Executive Office of Elder Affairs has been the contracting agency for the former Department of Social Services Elder Protective contracts. There are twelve (12) agencies involved in the current Elder At Risk Program (EAR), including nine (9) Boston and three (3) Worcester agencies. The program continues to be funded through a private/public partnership of 75 percent public funds to a 25 percent ratio of private funds.

The goal of the EAR contract is to target frail, self-neglecting, marginally competent elders, living in the community, who are often not otherwise eligible and/or willing to accept services.

Individual and/or family alcoholism and mental health problems, which impact on the elder's functional status are appropriate issues for inclusion under this contract. Intervention, designed to alleviate problems which otherwise might lead to the elder's eviction, is also seen as appropriate by Elder Affairs.

Our intention is to provide problem-focused, goal-oriented, casework/counseling which is designed to alleviate the factors that are placing the elder at risk.

The key indicator for deciding appropriateness for inclusion in the EAR program, is whether the client is "at risk" due to any existing problems. Operationally defined, an elder is "at risk" if that elder would not be able to safely remain in the community without agency intervention.

The Office of Elder Affairs plans a major statewide expansion of the Elder At Risk program, using current EAR funds, to address the needs of at-risk elders in all the communities of the Commonwealth.

The Homeless Program

This is a program, funded at the Boston III Home Care Corporation, which is designed to provide services to homeless elders in Boston. Most of these elders require intensive casework intervention. Seventy-eight (78) such cases were open in FY '89. Services provided can include health care coordination, transportation, assistance in the housing search, placement in temporary emergency housing, placement in permanent housing, assessment of the need for guardianship or conservatorship and home care services.

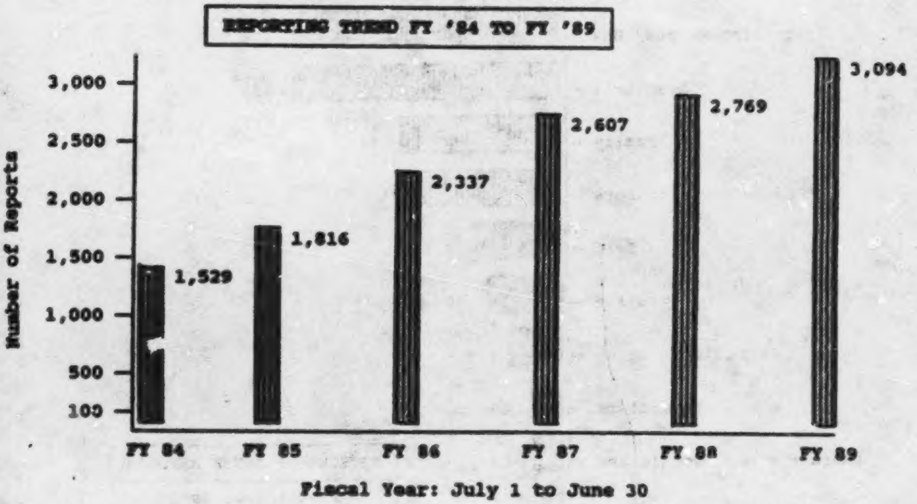
In addition, caseworkers assist clients in accessing income and benefits for which they may be eligible, in obtaining legal assistance and in receiving evaluation and treatment. The Homeless Elders Program has been successful in obtaining temporary and permanent housing for many homeless elders.

For six years, Ms. W., age 64, slept in doorways on the streets of Boston or in subways. On one occasion she suffered frostbite. Ms. W., a graduate of an elite Massachusetts college, had worked as a business woman in resorts for most of her life. Ms. W. had never married. Related in part to a broken relationship with a close friend, Ms. W. developed a serious depression during which she left her home. The Homeless Program Caseworker was able to gradually win her trust, and provided Ms. W. with temporary shelter and referral for counseling. Now on medications, Ms. W. appears more outgoing, energetic and has made friends at shelters. Ms. W. is now off the street, and due to the efforts of the caseworker, Ms. W. has a part-time job, has discovered $53,000 in assets and expects to move into permanent housing shortly.

FY'89 Accomplishments

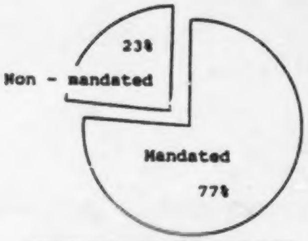
PROTECTIVE SERVICES AGENCIES SERVICE PROVISION

Increasing Reports of Abuse	Reports of abuse and neglect have increased from 1,529 reports in FY '84 to 3,094 reports in FY '89, or an increase of 102 percent in six (6) years. Reports made in FY '89 increased 12 percent over FY '88.



Mandated Reporting

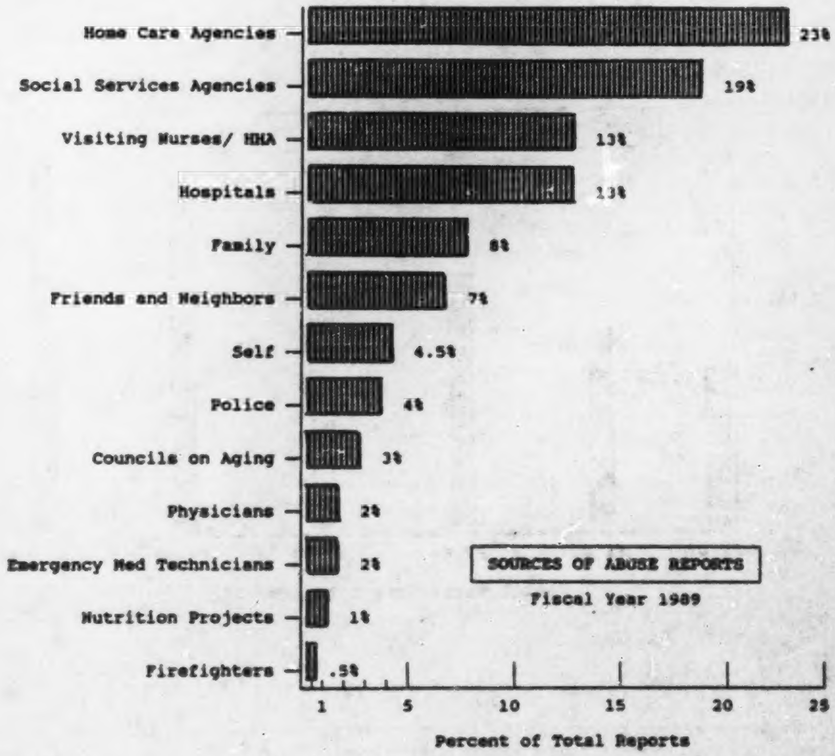
During FY '89, 3,094 reports of abuse and neglect were received. Mandated professionals filed 2,373 reports, while 721 reports were received from non-mandated reporters, such as family and neighbors. Self-referrals and friends contributed 587 of those non-mandated reports which were made, or 19 percent of the total reports received.



Reports Received FY'89

Sources of Reports

Sources of FY '89 reports for the Commonwealth broken down were:

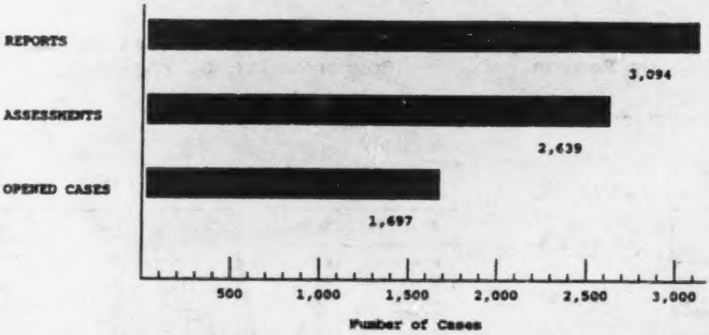


Reports Received and Cases Opened to Provide Protective Services

Of the 3,094 abuse and neglect reports received statewide in FY '89, 2,639 or 85 percent were assessed - in accord with 651 CMR 5.14 of the Protective Services Regulations. Of those cases investigated, 1,697 or 55 percent were found to involve abuse or neglect and were opened to provide Protective Services. Opened cases increased 12 percent over last year.

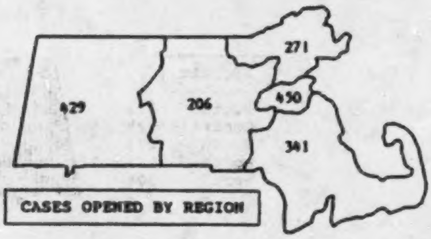
ELDER ABUSE STATE TOTALS

Fiscal Year 1989



Total Cases Opened by Region

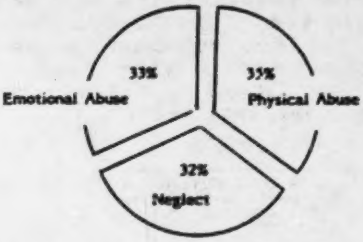
Cases opened for services provision in the Commonwealth during FY '89 by region were 450 Greater Boston, 429 Western Region, 341 Southern Region, 271 Northern Region and 206 Central Region. Greater Boston accounts for the greatest increase in Massachusetts protective cases, with a 33 percent increase over FY '88. Northern and Southern Regions each increased by 12 percent; the Western Region increased 1 percent and the Central Region decreased 6 percent.



CASES OPENED BY REGION

Types of Reports Physical Abuse Neglect and Emotional Abuse

Of the 1,697 cases opened throughout the Commonwealth, 592 or 35 percent involved physical abuse, 564 or 33 percent emotional abuse and 541 or 32 percent neglect as the primary case focus. Neglect and physical abuse cases increased, while the number of emotional abuse cases decreased over FY '88. It is noted that cases often involve multiple forms of abuse and neglect.



Types of Abuse by Region

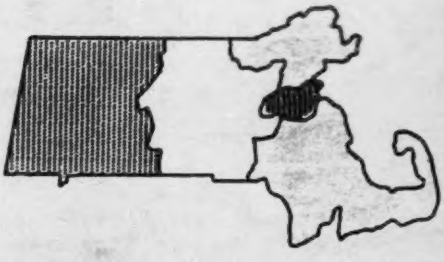
Types of abuse cases opened across the Commonwealth by region:

PERCENT OF STATE TOTAL

☐ 10 to 15%
☐ 16 to 20%
▨ 21 to 25%
▨ 26 to 30%
■ 31 to 35%

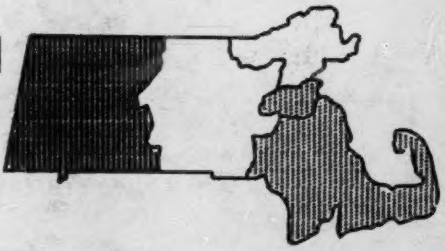
PHYSICAL ABUSE

Boston	26%
Central	14%
South	20%
North	19%
West	21%



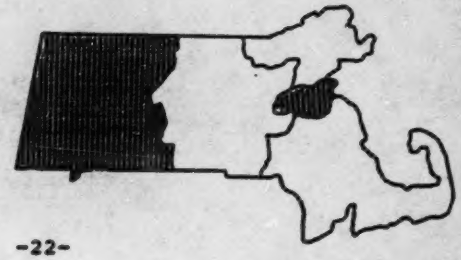
EMOTIONAL ABUSE

Boston	24%
Central	10%
South	23%
North	17%
West	26%



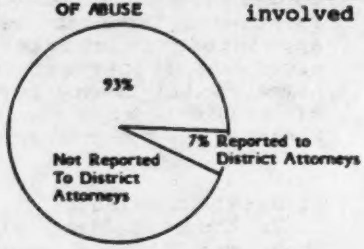
NEGLECT

Boston	29%
Central	12%
South	17%
North	12%
West	30%



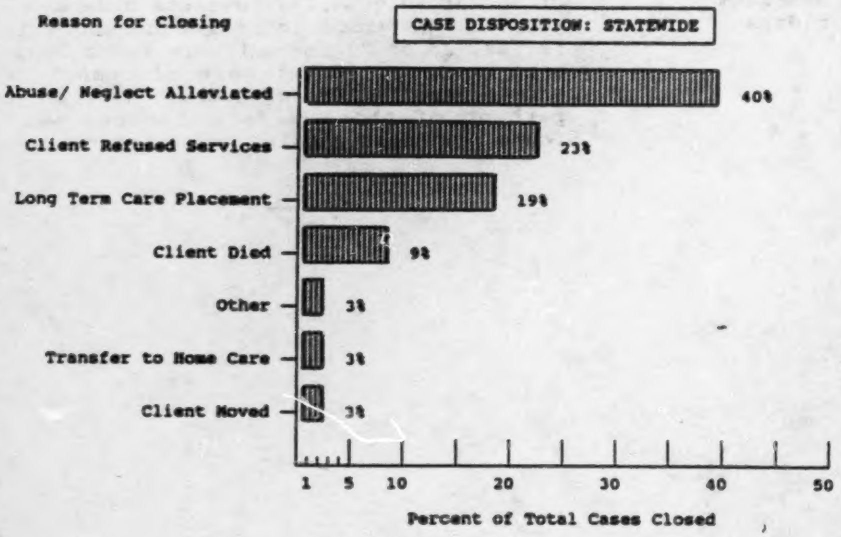
Reports to District Attorneys

A total of 123 cases involving serious injury were reported to District Attorneys, or 7 percent of those cases assessed and determined to have involved abuse.



Case Disposition

Of the 1,641 cases closed in FY '89, 65 percent were closed, following successful Protective Services intervention to alleviate or eliminate abuse, which includes long-term care placement and transfer to Home Care. Thirty-five percent were closed due to refusal of services, client moves and death.



Guardianship

As of June 30 1989 Guardianship Contractor Agencies served as guardians, conservators, or representative payees for seventy (70) elders. Of these cases 42 percent were Guardianships, 24 percent Conservators, 5 percent Representative Payees and 6 percent were awaiting court appointed fiduciaries. Thirty eight elders or 59 percent resided in nursing homes, while twenty seven (27) elders or 41 percent were being served while residing in the community.

Elder Abuse Hotline

Of 5,663 incoming calls received by the Elder Abuse Hotline, 270 were reports of abuse and 221 were requests for emergency intervention on open Protective Services cases. This is an increase in cases of abuse reported to the Elder Abuse Hotline of 41 percent and a 10 percent increase in cases requiring after-hours emergency response, over FY '88. Elder Affairs staff was contacted after hours for consultation on thirty-two (32) cases. Remaining calls involved requests for information and referral, and Protective Services Caseworker alerts to potential emergency after-hours cases.

Homeless Elders

Of seventy-eight (78) homeless elders who were provided intensive casework in FY '89, 25 or 32 percent were found long-term housing, foster care placement or were placed in nursing homes. Ninety-two percent of those elders placed, were found permanent housing or foster care.

SPECIAL PROJECTS

Special projects were undertaken in FY '89 by the Executive Office of Elder Affairs Protective Services Unit to bring about program modifications, resulting in improved services to abused elders.

Statewide Survey on Self-neglecting Elders

In conjunction with Mass. Home Care Association, Elder Affairs conducted a survey of twenty seven (27) Home Care Corporations to determine the extent of self neglect among the elderly in the Commonwealth of Massachusetts. Elder Affairs also conducted a second survey of all Councils on Aging, housing authorities, police departments, ambulance services and nutrition programs in the Commonwealth. In all, 1300 surveys were mailed and 130 or 10 percent were returned. Results of the survey were received and compiled during FY '89.

The twelve (12) Boston and Worcester Elder At Risk agencies were not included in either survey. Information was gathered separately from the Boston and Worcester Elder At Risk agencies, through program audits and staff interviews.

The overall focus of both surveys was documentation of the incidence of self neglect, the major factors leading to elders being "at risk," the incidence of alcohol and mental health problems in identified self-neglect cases, and the major service problems/gaps in the Commonwealth.

The two surveys were consistent in that both groups identified alcohol as a factor in 17 percent of all referrals. Mental health problems were a significant factor leading to self neglect in both surveys, but were identified in a higher number of Home Care Corporations - 54 percent in Home Care cases as compared to 29 percent in other service provider contacts.

There was also considerable agreement between the two populations surveyed as to the major problems or barriers to obtaining services for elders at risk. The most commonly identified problems were: the elder's refusal of help, a lack of identified caseworkers, a lack of services/providers, a lack of guardians and that these cases are very time consuming for Home Care casemanagers.

While both surveys were exploratory in nature and were designed to estimate numbers of a previously unidentified population, the surveys have indicated a significant problem which exists throughout the Commonwealth.

Elder At Risk Program Audits

Each of the twelve Elder At Risk programs was reviewed through case audits and interviews with staff. In addition, staff from Elder Affairs interviewed other providers of Elder Services in order to assess interagency cooperation and utilization of the Elder At Risk contracts. This review process, in conjunction with the self-neglect surveys, provided a framework for the direction of the Elder At Risk Program.

Elder At Risk Request for Proposals

A request for Proposals (RFP) for the Elder At risk Program was issued in February, 1989 on a statewide basis for contracts to begin July 1, 1989. Bidders conferences were held in Ludlow and Boston. As a result of concerns raised at these meetings, Elder Affairs suspended the RFP process and eventually cancelled the bidding for a July 1, 1989 start-up. Contracts with FY '89 providers were renewed July 1, 1989 through December 31, 1989 in order to provide a transition and planning period for current clients. A new RFP was issued on July 1, 1989 for contracts to begin January 1, 1990.

Mrs. S., a frail and memory impaired, 90-year-old, childless widow, was threatened with eviction due to leaving her stove on and causing several fires. Mrs. S. was unable to pay her bills and lived in a cluttered apartment with her dog who was eliminating inside because she could no longer go outdoors to walk him. Mrs. S. would deny her own limitations, and so would refuse the help of family and Home Care services stating that she did not need assistance. The Elder at Risk Caseworker was able, over several months time, to gain Mrs. S's. trust and obtain her permission to contact the landlord, and obtain help from family and service providers to allow her to remain at home and live independently. A great-nephew agreed to confront Mrs. S. about the need to stop using her stove. It was disconnected, and a microwave and Meals On Wheels were provided. A neighbor brings sandwiches in the evenings. A Homemaker now cleans the apartment and walks the dog, while a niece pays Mrs. S's. bills. Although Mrs. S. lives marginally in a dirty and cluttered apartment, she is happy about her continued independence and is no longer at risk of eviction.

Revision of Protective Services Regulations

In response to the legislature's passage of Chapter 566, which revised M.G.L. c.19A, Protective Services Regulations (651 CMR 5.00-5.35) were changed to reflect these statutory amendments. Protective Services Regulations now incorporate:

The addition of Firefighters, Emergency Medical Technicians and licensed Psychologists as mandated reporters of elder abuse and neglect.

Clarification of the need to insure the appointment of legal counsel and/or a guardian ad litem in Probate Court hearings on Protective Orders.

The change in legal standard from "clear and convincing" to "preponderance of the evidence" in court hearings regarding capacity to consent.

An extension of emergency protective orders from seventy two (72) hours to fourteen (14) days.

Clarification of reimbursement for medical care, mental health care, and emergency financial assistance. Elder Affairs and its designated agencies are authorized to arrange for such services, but are not legally responsible for the payment for these services.

Use of Protective Orders to gain access to and investigate reports of abuse and/or neglect of elders when such access is barred by persons other than the elder.

Reporting of serious abuse or death to District Attorneys in the county in which the abuse occurred.

Circumstances under which reports of threats of serious abuse may be made to the District Attorney.

Use of a Protective Order for obtaining an evaluation of an elder's capacity to consent to services when the elder is at risk of serious injury due to abuse and/or neglect, is believed to lack the capacity to consent to services, and refuses to allow an evaluation.

Full reporting to District Attorneys of all case information and investigations in situations of serious abuse.

State Agency Linkages

Elder Affairs began meeting with the Department of Mental Retardation (DMR) to initiate a protocol for handling cases that involve mentally retarded clients who have been abused or neglected in the community. In addition, Elder Affairs began to work with the Department of Mental Health and the Department of Mental Retardation to clarify responsibilities with regard to reports of abuse and neglect.

Hotline Collaboration with Disabled Persons' Commission

Elder Affairs and the Disabled Persons' Protection Commission joined together to contract with the same agency to provide 24-hour Hotline coverage. This resulted in an annual savings of over $40,000 for Elder Affairs and more efficient use of Hotline staff.

Statewide Videotape Lending Library

A statewide Elder Protective Services lending library of fourteen (14) training videotapes was initiated. Tapes cover such topics as; dealing with hostile family members, reporting serious abuse to District Attorneys, ethical dilemmas in providing Protective Services, client confidentiality, cross-cultural casework issues, and preparing and giving court testimony. Over one-third of the designated, statewide, Protective Services Agencies used tapes for Protective Services and Home Care staff training during the first six months of operation in FY '89. Ongoing expansion of this library continued through the taping of other seminars and workshops.

Investigation of Reports of Death

Elder Affairs issued a program instruction which clarified sections of M.G.L. c. 19A and 651 CMR 5.00 regarding receipt of reports that an elder has died as the result of abuse or has died during the assessment of a report of abuse. The purpose of this program instruction was to delineate a procedure which was in compliance with the statute and regulations and provided maximum cooperation with law enforcement agencies in situations which could result in a criminal investigation.

> Hospital staff reported that Mrs. L., who was admitted weighing 70 lbs and unconscious, was severely dehydrated and malnourished, and had several infected, two-inch-deep decubiti. Mrs. L. had been living with her two daughters who had failed to provide food, water and turning of their bed-bound mother. Because Mrs. L's. decubiti went untreated, they became infected. During Mrs. L's. three-week hospitalization, she never regained consciousness before dying. A report of elder death, due to neglect, was made by Protective Services staff to the District Attorney's office, however no prosecution was initiated as current criminal statutes do not cover neglect.

Emergency Protective Services

Elder Affairs issued a Program Instruction revising the approval process for utilization of Emergency Protective Services Contracts. In an effort to be consistent with general casework practice, the decision to approve or disallow a request for emergency funds was shifted from Elder Affairs to the designated Protective Services Agencies.

Standards of Practice: Protective Services Intake

A Task force comprised of Elder Affairs and Protective Services Caseworkers and Supervisors was formed to begin the process of developing written standards of practice for the Protective Services Program.

During FY '89, this task force developed Standards of Practice for receiving, screening and responding to reports of abuse and neglect. Intake Standards of Practice were developed for dissemination to the twenty seven (27) designated Protective Services agencies in FY '90 (please see Appendix C - Intake Standards of Practice). The Task Force will continue meeting to begin developing Assessment/Functional Evaluation Standards of Practice in FY '90.

StateWide Data Collection

The first of three revisions in documents used to collect statewide data on elder abuse was completed. A Data Collection Task Force was organized and revisions were made to the Elder Abuse Intake Form ((please see Appendix D - Elder Abuse Intake Form). Information now collected during the filing of a report or abuse or neglect, will result in:

> Improved information gathering to assist staff in determining the need for emergency or non-emergency response.

The gathering of more specific, factual information which more clearly identifies allegations and client needs for protection.

An instrument from which certain data, necessary for program management, may be computerized.

Clarification of risk to the caseworker in completing the Assessment.

Implementation of a pilot program is slated for FY '90.

Elder Neglect and Caretakers

Because of the complexity involved, both in identifying situations of elder neglect and in identifying those persons responsible for the elder's care, Elder Affairs' began development of a policy to clarify the existing regulatory definitions of caretaker and neglect. Issues have been identified by Protective Services Workers and Supervisors and by designated agency administrators and attorneys. A Program Instruction will be issued during FY '90.

During the summer, a neighbor reported that Mrs. H. was locked inside a boarded-up, attic room by her son. The Protective Services Caseworker responded on an emergency basis, and found the attic to be over 100 degrees and the elder to be hungry and suffering from heat exhaustion. The son, a professor at a local college, was unsure how to care for his mildly demented mother, and had locked her upstairs in his house. Because adequate meals and ventilation were not provided, Mrs. H. was at risk of a medical crisis. The Caseworker convinced the son to move Mrs. H. from the attic, and set up Homemaker services and Home Delivered Meals. Mrs. H. is now safe, and living downstairs in her son's house.

Reimbursement for Interpreting Services

The ability of designated Protective Services Agencies to assess reports of abuse and to provide services needed to alleviate or eliminate situations of abuse, with non-English speaking elders, was improved with the authorization of reimbursement for interpreting services. Protective Services Agencies may now contract with agencies or individuals for this crucial service.

Guardianship Statistical Reporting

An improved monthly reporting form was developed which provides important information regarding client profiles, referral sources, the legal process and case disposition. In addition, utilization of this form resulted in a reduction of paperwork for field staff.

Definition of an Open Guardianship Case after the Death of a Ward

A policy was develcped and promulgated to clarify how long a guardianship case may remain open after a Ward has died. Timeframes for case closings were specified. Guidelines for procedures and alternatives in settling the Ward's estate were provided to guardianship agencies.

Guardianship Program Monitoring

Guidelines for the auditing of Elder Affairs' guardianship contractors were formulated and a Program Instruction was drafted. Upon the issuance of this Program Instruction in FY '90, Guardianship agencies will be provided with clear standards of practice to insure that clients who are adjudicated incompetent are not only protected from abuse or neglect, but are insured of caring treatment and the protection of their rights.

Two elderly sisters, Miss K. age 89 and Mrs. H. age 85, had lived together in their apartment for the last 50 years. When Miss K. was hospitalized for dehydration, Mrs. H. expressed concern to staff that she was unable to care for her sister and could no longer feed her. While Home Care services had maintained both sisters at home for several years, Miss K. was diagnosed with organic brain syndrome, had become incontinent and could not be left unsupervised. Care needs were more than could be provided at home. Mrs. H. refused to allow her sister to be placed in a nursing home. The Protective Services Caseworker obtained a guardian for Miss K.. Because the planned placement was upsetting to both sisters, the Guardian had to win their trust and prepare them for Miss K's. move. After placement, Mrs. H. became angry and agitated with the Guardianship Caseworker. However, the Caseworker continued to see Mrs. H. and assist with her financial needs and transportation to the nursing home for weekly visits to see her sister. Throughout this time, the guardian also assisted Mrs. H. with obtaining treatment for an eye tumor and tried to convince her to seek nursing home placement due to Mrs. H's. inability to care for herself. After 6 months, Mrs. H. fell and was unable to get off the floor for two days until found by her Homemaker. Following this, Mrs. H. agreed to allow the Guardianship Agency to be her Power of Attorney under a private pay program, and to enter a nursing home. The guardian was able to have Mrs. H. placed in the same nursing home as her sister, and eventually placed in the same room. While in the process of moving Mrs. H., the guardian, through the discovery of old Christmas cards, wrote to friends of the sisters, and several have since visited. Because of the persistent and caring efforts of the caseworker, both sisters are now safe and quite pleased to be living together again.

Guardianship Legislation

Guardianship legislation from nineteen (19) states, pending federal legislation, and information on abuses of guardianship was obtained in preparation for review and the filing of legislative amendments to increase the protection of elder rights while improving care by fiduciaries. The review and drafting of recommended changes in Massachusetts law was not completed during FY '89 due to a shortage of staff.

Guardianship Cost-sharing

Development of a Guardianship, cost-sharing fee structure was initiated during FY '89, but was not completed due to staff shortages.

Homeless Program

A Program Design was completed during FY '89, clarifying the population of elders served and to provide program goals, definitions and procedures. Written guidelines were established for receiving program referrals and subcontracting for services.

Elder Abuse Hotline RFP

A Request For Proposals was issued for the statewide Elder Abuse Hotline and the contract award was received by the current contractor, Greater Lawrence Mental Health Center. Contract Attachment A was revised to insure written procedures are in place to provide for continuity of coverage when equipment malfunctions occur, and to insure coordination with the DPPC Hotline.

Hotline Publication

An agreement was reached with New England Telephone whereby the Elder Abuse Hotline phone number will be listed statewide in the Crisis Box section of the emergency services numbers as local phone books are revised.

A social worker witnessed Mr. W. shaking after his daughter had screamed at him, threatening to no longer allow him to live in her house. Several years ago, Mr. W. financed the building of an apartment addition onto his daughter's house, with the understanding that he would live there. The Protective Services Caseworker learned that once Mr. W. had moved in, he became isolated, was not eating regularly, and had become forgetful and repetitious. Additionally, the daughter was upset with her father's accusations that her family was stealing from him.

Mr. W. was offered legal representation, and the daughter and her husband were convinced to attend a caregivers support group and to seek counseling. Mr. W. accepted meals and personal care. A gerontological evaluation was obtained and with nutritional improvements, Mr. W's. forgetfulness and paranoia decreased. His daughter has since allowed him to remain in their home, and the yelling and threats have stopped.

Protective Services Training/ Conferences

Workshops, Conferences and training provided during FY '89 included:

National

Innovative Practices: Working with Law Enforcement and the Courts
1988 Adult Protective Services Conference
San Antonio, Texas

The Executive Office of Elder Affairs and the Middlesex County District Attorney's Office presented a protocol which was jointly developed by both offices. The protocol describes procedures by which the Protective Services System and the Criminal Justice System in Massachusetts can provide a coordinated response to cases of severe abuse. The protocol implements cooperative practices between two systems with different mandates

Commonwealth of Massachusetts

7th Annual Governor's Conference on Aging
Southeastern Massachusetts University

Elder Affairs protective services staff organized, moderated or presented in three (3) workshops:

The Unsuspecting Addict

A panel composed of substance abuse specialists, a legislator and a Protective Services Regional Supervisor presented on the effects of the interactions among over-the-counter medications, prescribed medications, and alcohol on elders. Substance abuse is a major causative factor in elder abuse and may also severely impair the elder's capacity to consent to Protective Services.

Vulnerable Elders

This panel of Elder Affairs, Home Care Cooperations and Family Service Agency Staff presented on establishing a program for elders who are at risk in the community. Panelists discussed the difference between elders who are neglected by a caretaker and those who have no caretaker, the benefits of a programmatic rather than legislative approach to address the needs of elders at risk, problems associated with assisting the homeless and casework techniques in helping vulnerable elders.

Public Guardianship

Attorneys, a public guardian and advocates for legislative changes in Massachusetts guardianship law presented both sides of a national debate on benefits and problems associated with public guardianship.

Protective Services in Massachusetts: Statewide Seminar for Medical Examiners and Law Enforcement

Elder Affairs presented the Mandatory Reporting M.G.L. c. 19A, s. 14-26 as part of an afternoon of education on laws which affect participants, along with the Department of Social Services and the Disabled Persons' Protection Commission.

Board of Directors Conference: Home Health/Respite Care/Protective Services

A panel of Elder Affairs and Home Care Corporation Staff presented the three newest programs available to Home Care clients. The Protective Services presentation focused on the role and responsibility of the Board of Directors in providing a legally mandated service.

Guardianship in Massachusetts
Massachusetts Commission for the Blind

Elder Affairs participated in an afternoon of training about guardianship, alternatives to guardianship, and the program administered by Elder Affairs under the Protective Services Program

Massachusetts Council on Aging (MCOA) Conference

Elder Affairs participated on a panel to discuss the realities of guardianship and the alternatives available. Panelists focused on the need to use the least restrictive alternative available, and pursuing guardianship only when no other avenue is available to protect the elder.

Elder Services Corps

Elder Services Corps participants were trained in the reporting requirements of Protective Services, the identification of elder abuse and neglect, and the service interventions provided by Protective Services Caseworkers

Amended Protective Services Regulations

Mandatory training for Protective Services Workers and Supervisors were held throughout the Commonwealth. Many designated Agencies' Executive Directors and attorneys, as well as Guardianship Agency staff also attended these trainings.

3rd Annual Protective Services Recognition Day and Conference

For the third consecutive year, Elder Affairs sponsored an all-day Protective Services conference in recognition of the commitment and professionalism of Protective Services and Guardianship Staff. Approximately 100 participants attended this event held at Holy Cross College in Worcester. Workshops included topics such as preparing for court testimony, supervision, ethical dilemmas in providing Protective Services, and cultural issues. The Edward R. McCarthy award was presented by Secretary Lanzikos to Gerald B. West, Protective Services Supervisor at Greater Springfield Senior Services in recognition of his expertise and contribution to Elder Protective Services.

Regional Training

Protective Services Conference

Health and Social Services Consortium - Foxboro

Mandated Reporting

Police Officers of Middlesex County participated in a panel discussion of Elder Abuse and mandatory reporting requirements as part of the Middlesex District Attorney's office conference, "Police Response to Domestic Violence and Elder Abuse."

Elder Protective Services Program

Massachusetts Legislature - introduction of the Executive Office of Elder Affairs programs to new legislators.

Guardianship Alternatives

A presentation was made to the social work and nursing staff of Whidden Hospital on limits and restrictive nature of guardianship as an intervention with elders. Alternatives to guardianship were offered and discussed.

Elder Protective Services in Massachusetts

A presentation on the Massachusetts Elder Abuse Program was made on "Press Conference", a WUPE (Pittsfield) radio talk show.

FY'90 Initiatives

The Executive Office of Elder Affairs Protective Services Unit plans to undertake a number of initiatives in FY '90.

Intake Standards

Intake Standards of Practice developed in FY '89 will be issued and statewide training provided.

Elder Abuse Intake Form

The revised Elder Abuse Intake Form (Data Collection Instrument [DCI- 1]) will be issued as a six (6) month pilot program and statewide training provided. Comments and recommendations for revisions will be received, and necessary changes made.

Assessment Standards

The Standards Task Force will develop and submit to Elder Affairs proposed Assessment/Functional Evaluation Standards of Practice. Standards policy will be finalized for issuance of a Program Instruction during FY '91.

Assessment Form

A draft of the revised Assessment/Functional Evaluation Form (DCI-2) will be developed for review by the Statewide Data Collection Task Force. Issuance of DCI-2 is planned for FY '91 in conjunction with the Assessment Standards of Practice.

Statewide Elder at Risk Program

A statewide Request for Proposals will be issued in July 1989 for the contracting period of January 1 to June 30, 1990 in order to expand the EAR program to serve at-risk elders in all communities of the Commonwealth. RFPs will be reviewed and contracts awarded. Meetings will be held with present providers to insure a smooth transition of clients between service providers when contractor agencies are changed. Elder at Risk Programs will be established throughout the Commonwealth, technical assistance provided and statewide training held. Program design improvements will be made.

Public Awareness of Elder Abuse

A campaign will be planned and initiated to increase public awareness of the problem of elder abuse and neglect, and to provide information on elder abuse reporting. During FY '90, statewide mandated reporter organizations will be targeted and contacted to offer and provide training. Plans will be made to target the general public during FY '91.

Agreements with District Attorneys

As an expansion of work begun in FY '88, Elder Affairs will meet with District Attorneys in three (3) counties to further develop cooperative working agreements around the reporting and handling of Protective Services cases. Joint trainings will be held between District Attorney and Protective Services staff on protocol and clarifying what can be expected of each agency.

Protective Services Agency Audits

Elder Affairs staff will evaluate the frequency and content of current Protective Services Agency case and program reviews, and develop written procedures for the monitoring and evaluation of Protective Services programs.

Clarification of Neglect Cases	In FY '90, a Program Instruction will be issued to clarify regulatory definitions of caretaker and neglect. Protective Services forms including the District Attorney Reporting Form, Notification of Assessment, Elder Abuse Intake and Mandated Reporter Form, will be revised to reflect this Program Instruction.
Guardianship Program	During FY '90, Elder Affairs staff will review the current guardianship program to determine needed development and begin planning for FY '91.
Guardianship Cost-Sharing	Development of a fee structure whereby services for guardianship will be shared with the Ward will begin during FY '90. Cost-sharing will allow the Commonwealth to recover costs of guardianship from Wards based on their income and assets. On occasion, elders with substantial assets, suffering from abuse, for whom no community person will act as guardian, are accepted into this program.
Training	Plans will be made to provide statewide training through the Protective Services Recognition Day.

CRF/cb

1985 Amendment. St.1985, c. 755, approved Jan. 6, 1986, in the third paragraph, rewrote cl. (c).

1986 Legislation

St.1986, c. 563, approved Dec. 8, 1986, in the clause relating to home care programs, inserted the requirement relating to the appointment of a majority of the governing body of the home care providers by the councils on aging of the cities and towns served by the provider and the paragraphs relating to contracts with home care providers that do not comply with the requirements relating to composition of the governing body.

Code of Massachusetts Regulations

Home care program, regulations governing, see 651 CMR 3.01 et seq.

Prior Laws:

G.L. c. 6, § 73, as added by St.1954, c. 537, § 2.
St.1955, c. 591.
St.1964, c. 430, § 2.
St.1967, c. 765, § 4.

§ 4A. Sliding fee scale for home care services; financial eligibility limits

The department shall establish a sliding fee scale to provide home care services for certain persons whose income exceeds the limits established under Title XX of the Social Security Act. On July first of each year, the department shall increase the financial eligibility limits for home services, including the sliding fee scale, by a percentage equal to the percentage increase in federal social security benefits for that fiscal year. The department shall forward to the house and senate committees on ways and means on or before March first of each year, a full report on the status of the home care program audit.

Added by St.1982, c. 357, § 5.

1982 Enactment. St.1982, c. 357, § 5, an emergency act, was approved July 20, 1982, and by § 21 made effective as of July 1, 1982.

§ 6. Regulations

Code of Massachusetts Regulations

Discrimination based on age, agencies receiving funds from department, see 651 CMR 8.01 et seq.

§ 14. Definitions applicable to sections 14 to 26

For the purposes of sections fourteen to twenty-seven [1], inclusive, the following words and terms shall, unless the context otherwise requires, have the following meaning:

"Abuse", an act or omission which results in serious physical or emotional injury to an elderly person; provided, however, that no person shall be considered to be abused or neglected for the sole reason that such person is being furnished or relies upon treatment in accordance with the tenets and teachings of a church or religious denomination by a duly accredited practitioner thereof.

"Caretaker", the person responsible for the care of an elderly person, which responsibility may arise as the result of a family relationship, or by a voluntary or contractual duty undertaken on behalf of an elderly person, or may arise by a fiduciary duty imposed by law.

"Conservator", a person who is appointed to manage the estate of a person pursuant to chapter two hundred and one.

"Court", the probate and family court.

"Department", the department of elder affairs.

"Elderly person", an individual who is sixty years of age or over.

"Emergency", a situation in which an elderly person is living in conditions which present a substantial risk of death or immediate and serious physical or mental harm.

"Guardian", a person who has qualified as a guardian of an elderly person pursuant to chapter two hundred and one, but shall not include a guardian *ad litem*.

"Protected person", an elderly person for whom a conservator or guardian has been appointed or other protective order has been made.

"Protective services", services which are necessary to prevent, eliminate or remedy the effects of abuse to an elderly person.

"Protective services agency", a public or nonprofit private agency, corporation, board, or organization designated by the department pursuant to this chapter to furnish protective services to elderly persons.

Added by St.1982, c. 604, § 1. Amended by St.1987, c. 566, § 1.

[1] So in original; probably should read "twenty-six".

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 26, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

Sections 1A and 2 of St.1982, c. 604, provided:

"Section 1A. The department of elder affairs shall, subject to appropriation, implement the provisions of section one of this act on or before July first, nineteen hundred and eighty-three.

"Section 2. If any provision of the act, or the application thereof to any person or circumstance, is held invalid, such invalidity shall not affect any other provision or application of the act which can be given effect without the invalid provision or application, and to this end the provisions of the act are declared severable."

1987 Legislation

St.1987, c. 566, § 1, approved Dec. 14, 1987, deleted the definition of geriatric evaluation process, which read:

"'Geriatric evaluation process', a team of medical psychological, psychiatric, social work professionals designated or established by the department for the purpose of conducting comprehensive physical, mental, social evaluation of an elderly person."

§ 15. Reports of abuse; liability

(a) Any physician, a medical intern, dentist, nurse, family counselor, probation officer, social worker, policeman, firefighter, emergency medical technician, licensed psychologist, coroner, registered physical therapist, registered occupational therapist, osteopath, podiatrist, executive director of a licensed home health agency or executive director of a homemaker service agency who has reasonable cause to believe that an elderly person is suffering from or has died as a result of abuse, shall immediately make a verbal report of such information or cause a report to be made to the department or its designated agency and shall within forty-eight hours make a written report to the department or its designated agency. Any person so required to make such reports who fails to do so shall be punished by a fine of not more than one thousand dollars.

(*b*) The executive director of a home care corporation, licensed home health agency or homemaker service agency shall establish procedures within such agency to ensure that homemakers, home health aides, case managers or other staff of said agency who have reasonable cause to believe that an elderly person has been abused shall report such case to the executive director of the corporation or agency. The executive director shall immediately make a verbal report of such information or cause a report to be made to the department or its designated agency and shall within forty-eight hours make a written report to the department or its designated agency.

(*c*) In addition to a person required to report under the provisions of subsection (*a*) of this section, any other person may make such a report to the department or its designated agency, if any such person has reasonable cause to believe that an elderly person is suffering from or has died as a result of abuse.

(d) No person required to report pursuant to the provisions of subsection (a) shall be liable in any civil or criminal action by reason of such report; provided, however, that such person did not perpetrate, inflict or cause said abuse. No other person making such a report pursuant to the provisions of subsection (b) or (c) shall be liable in any civil or criminal action by reason of such report if it was made in good faith; provided, however, that such person did not perpetrate, inflict or cause said abuse. Any person making a report under subsection (a), (b) or (c) who, in the determination of the department or the district attorney may have perpetrated, inflicted or caused said abuse may be liable in a civil or criminal action by reason of such report. No employer or supervisee may discharge, demote, transfer, reduce pay, benefits or work privileges, prepare a negative work performance evaluation, or take any other action detrimental to an employee or supervisee who files a report in accordance with the provisions of this section by reason of such report.

(*e*) Reports made pursuant to subsections (*a*) and (*b*) shall contain the name, address and approximate age of the elderly person who is the subject of the report, information regarding the nature and extent of the abuse, the name of the person's caretaker, if known, any medical treatment being received or immediately required, if known, any other information the reporter believes to be relevant to the investigation, and the name and address of the reporter and where said reporter may be contacted, if the reporter wishes to provide said information. The department shall publicize the provisions of this section and the process by which reports of abuse shall be made.

(*f*) Any privilege established by section one hundred and thirty-five of chapter one hundred and twelve or section twenty B of chapter two hundred and thirty-three relating to the exclusion of confidential communications shall not prohibit the filing of a report pursuant to the provisions of subsection (a), (b) or (c).

Added by St.1982, c. 604, § 1. Amended by St.1987, c. 566, §§ 2 to 4.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

1987 Legislation

St.1987, c. 566, § 2, approved Dec. 14, 1987, in the first sentence of subsec. (a), inserted "fire-fighter, emergency medical technician,", and deleted "aid" following "executive director of a licensed home health".

Section 3 of St.1987, c. 566, in subsec. (d), added the provisos to the first and second sentences, and inserted the third sentence.

Section 4 of St.1987, c. 566, added subsec. (f).

Library References

Asylums ⇨3.

Physicians and Surgeons ⇨10.

C.J.S. Asylums and Institutional Care Facilities §§ 5 to 8.

C.J.S. Physicians and Surgeons §§ 31 to 35.

WESTLAW Electronic Research

See WESTLAW Electronic Research Guide following the Preface.

§ 16. Protective services system

(*a*) Subject to appropriation, the department shall develop a coordinated system of protective services for elderly persons who are determined to be abused. In planning this system, the department shall require input from the department of social services, the existing protective service agencies and other agencies currently involved in the provision of social, health, legal, nutritional, and other services to the elderly, as well as elderly advocacy organizations.

(*b*) Within this protective services system, the department shall establish a mechanism for the receipt of reports made pursuant to section fifteen which shall operate and be accessible on a twenty-four hour per day basis. If the department or its designated agency has reasonable cause to believe that an elderly person has died as a result of abuse, the death shall be reported immediately to the district attorney of the county in which the abuse occurred. Within forty-five days of the receipt of a report made pursuant to subsection (*a*) of said section fifteen, the department or its designated agency shall notify the reporter, in writing, of its response to the report. Such notification shall be made to a person who makes a report pursuant to subsection (*c*) of said section fifteen if said reporter so requests.

(*c*) Subject to appropriation, the department shall designate at least one local agency to act on behalf of the department with a geographic area as defined by the department. The department may designate any public agency or private nonprofit organization which has the capacity to implement a service plan through direct access to social, health and mental health services. The department shall utilize existing resources and services of public and nonprofit private agencies in providing protective services. The department shall insure that assessment, evaluation and service delivery shall be provided through the designated local agency closest to the elderly person's community.

In designating agencies, the department shall insure that: (1) persons conducting assessment, evaluation and service delivery have demonstrated experience in providing protective and other social health services to elders, have these protective functions as their primary employment responsibility, and have other professional qualifications as determined by the secretary; (2) continuity of care under one protective services worker is assured throughout assessment, evaluation and services delivery to the extent possible; and (3) the department and the designated agencies have the capacity to respond to an emergency and provide or arrange for services to alleviate the immediate danger of abuse of an elderly person on twenty-four hours per day basis.

The department shall monitor assessments, evaluations and the provision of protective services by designated local agencies.

(d) The department shall issue regulations establishing criteria and procedures for the designation of protective services agencies or for the termination or designation or redesignation of protective services agencies.

(e) The department shall be responsible for continuing coordination and supervision of the system. In carrying out these duties, the department shall, subject to appropriation: (1) adopt rules and regulations for the system; (2) continuously monitor the effectiveness of the system and perform evaluative research about it; and (3) utilize grants from federal, state and other public and private sources to support the system.

Added by St.1982, c. 604, § 1. Amended by St.1987, c. 566, § 5.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

1987 Legislation

St.1987, c. 566, § 5, approved Dec. 14, 1987, in the second sentence of subsec. (b), substituted "abuse occurred" for "elderly person resided".

§ 17. Protective services agencies; authorized activities

A protective services agency is authorized:

(1) to receive and investigate reports of abuse;

(2) to furnish protective services to an elderly person with his or her consent;

(3) to petition the court for appointment of a conservator or guardian or for issuance of an emergency order for protective services;

(4) to furnish protective services to an elderly person on an emergency basis as hereinafter provided;

(5) to furnish protective services to a protected person with the consent of such person's guardian or conservator;

(6) to serve as conservator, guardian, or temporary guardian of a protected person; and

(7) to perform all other functions determined by the department to be necessary for the administration of this chapter.

Added by St.1982, c. 604, § 1.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

§ 18. Assessment and evaluation of reports; investigations; arrangement for protective services

(a) The department or its designated agency shall assess and evaluate the information reported pursuant to the provisions of section fifteen.

Such assessment shall include a visit to the residence of the elderly person who is the subject of the report and may include consultations with appropriate service agencies and individuals who have knowledge of the elderly person's situation including the person filing the report. The elderly person who is the subject of the report shall receive written notice that an assessment is being conducted and shall have the right to review the file and report developed as a result of the assessment.

If the assessment results in a determination that the elderly person is suffering from abuse, the department or the designated agency shall evaluate the elderly person's functional capacity, situation, and resources and shall develop a service plan for the provision of protective services. Said plan shall be appropriate to the needs of the elderly person and shall utilize the least restrictive alternatives.

The department shall adopt rules and regulations establishing time limits for the completion of assessments and evaluations and for the implementation of service plans: provided, however, that if an emergency exists, assessments shall be completed within twenty-four hours of the receipt of the report.

If an assessment results in a determination that the elderly person has suffered serious abuse, the department or designated agency shall report such determination to the district attorney of the county where the abuse occurred within forty-eight hours. The district attorney may investigate and decide whether to initiate criminal proceedings.

(b) The department or the designated agency shall provide or arrange for protective services in accordance with the service plan developed pursuant to the provisions of subsection (a). Protective services shall include, but not be limited to, the following: the capacity to respond to an emergency; protective services case work; the capacity to provide or arrange for a homemaker, home-health aide, transportation, legal assistance, counseling, nutrition services, guardianship and conservatorship, protective order through the court, emergency shelter, foster care, and adult day care services.

The department or the designated agency is authorized to arrange for additional services necessary to assist and protect elderly persons who have been abused, including, but not limited to, the following: medical care, mental health care and emergency financial assistance.

Added by St.1982, c. 604, § 1. Amended by St.1987, c. 566, §§ 6, 7.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

1987 Legislation

St.1987, c. 566, § 6, approved Dec. 14, 1987, in the fifth paragraph of subsec. (a), in the first sentence, substituted "where the abuse occurred" for "within which the elderly person resides".

Section 7 of St.1987, c. 566, in subsec. (b), in the second sentence of the first paragraph, added ", emergency shelter, foster care, and adult day care services"; and, in second paragraph, deleted "provide or" following "is authorized to", deleted "emergency housing" following "the following:", and deleted ", foster care and adult day care services" following "emergency financial assistance".

§ 19. Consent to protective services; interference with provision of services

(a) Any elderly person who requests or affirmatively consents to the receipt of protective services may receive said services. If the person withdraws or refuses consent, the service shall not be provided or continued except as provided in section twenty.

(b) No person shall interfere with the provision of protective services to an elderly person who requests or consents to receive such services. In the event that interference occurs on a continuing basis, the department, a protective services agency, or the public guardian may petition the court to enjoin such interference.

Added by St.1982, c. 604, § 1.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

§ 20. Lack of capacity to consent to protective services; hearings; emergency orders; placement or commitment

(a) If the department or its designated agency has reasonable cause to believe that an elderly person is suffering from abuse and lacks the capacity to consent to the provision of protective services, the department or its designated agency may petition the court for a finding that the elderly person is incapable of consenting to the provision of protective services. Said petition shall set forth the specific facts upon which the department or the designated agency relied in making the determination. The court shall hold a hearing on the matter within fourteen days of the filing of the petition. The court shall give notice to the elderly person who is the subject of the petition at least five days prior to the date set for the hearing. The elderly person who is the subject of the petition shall have the right to be present, be represented by counsel, present evidence, and examine and cross-examine witnesses. If the elderly person who is the subject of the petition is indigent, the court shall appoint counsel to represent such elderly person. If the court determines that the elderly person lacks the capacity to retain counsel or waive the right to counsel, the court shall appoint a guardian ad litem to represent the interests of such elderly person. If, after hearing, the court determines, based on the preponderance of the evidence, that such elderly person has been abused, is in need of protective services and lacks the capacity to consent and no other person who is authorized to consent is available or willing to consent, the court may appoint a conservator, guardian or other person authorized to consent to the provision of protective services; provided, however, that the court shall establish the least restrictive form of fiduciary representation that will satisfy the needs of such elderly person. In addition to or in the alternative, the court may issue an order requiring the provision of services. The order shall contain a specific description of the services to be provided and insure that the least restrictive alternatives are utilized. An order for protective services for an elderly person pursuant to this subsection shall remain in effect for a period of six months, unless otherwise stipulated in such order. The court may, for good cause shown, extend an order for protective services. Such extension shall remain in effect for a period of six months, unless otherwise stipulated in such order.

(b) If an emergency exists and the department, its designated agency, a member of the immediate family or a caretaker has reasonable cause to believe that an elderly person is suffering from abuse and lacks the capacity to consent to the provision of protective services, said department, designated agency, member of the immediate family or caretaker may petition the court for an emergency order of protective services. The court shall give notice to the elderly person who is the subject of the petition at least twenty-four hours prior to the hearing. The court may dispense with notice upon finding that immediate and reasonable foreseeable physical harm to the individual or others will result from the twenty-four hour delay and that reasonable attempts have been made to give such notice. If the elderly person who is the subject of the petition is indigent, the court shall appoint counsel to represent such elderly person. If after the hearing, the court determines, based on the preponderance of the evidence, that the elderly person has been or is being abused, that an emergency exists, and that the elderly person lacks the capacity to consent to the provision of services, the court may order the provision of protective services on an emergency basis. The court shall order only those services necessary to remove the conditions creating the emergency and shall specially designate the authorized services in its order. If the court determines that the elderly person lacks the capacity to retain counsel or waive the right to counsel, the court shall appoint a guardian ad litem to represent the interest of such elderly person following the entry of such emergency order. The order for emergency protective services shall remain in effect for a period not to exceed fourteen days. Said order may be extended for an additional period not to exceed fourteen days if the court finds that the extension is necessary to remove the emergency.

(c) The court shall not order an institutional placement or change of residence unless it finds that no less restrictive alternative will meet the needs of the elderly person. No elderly person may be committed to a mental health facility pursuant to this chapter. The

elderly person or his or her court-appointed representative, the department, or the designated agency may petition to have any order issued pursuant to subsection (*a*) or (*b*) set aside or modified at any time.

Added by St.1982, c. 604, § 1. Amended by St.1987, c. 566, §§ 8 to 10.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

1987 Legislation

St.1987, c. 566, § 8, approved Dec. 14, 1987, in the seventh sentence of subsec. (a), inserted "retain counsel or"; and in the eighth sentence, substituted "on the preponderance of the" for "upon clear and convincing".

Section 9 of St.1987, c. 566, in subsec. (a), added the least three sentences.

Section 10 of St.1967, c. 566, in subsec. (b), inserted the fourth sentence; in the fifth sentence, substituted "the preponderance of the" for "clear and convincing"; inserted the seventh sentence; in the eighth sentence, substituted "fourteen days" for "seventy-two hours"; and in the ninth sentence, substituted "period not to exceed fourteen days" for "seventy-two hour period".

§ 21. Geriatric evaluation process

(*a*) Subject to appropriation, the department shall establish a geriatric evaluation process for the purpose of conducting a comprehensive physical, mental, or social evaluation of an elderly person for whom a petition has been filed in a court for appointment of a conservator or guardian, under the provisions of clause (3) of section seventeen, or for an emergency order for protective services.

(*b*) The evaluation of an elderly person conducted by the geriatric evaluation process shall include at least the following:

(1) the name and address of the place where the person is residing and of the person or agency, if any, who is providing services at present;

(2) a description of the treatment and services, if any, presently being provided to the person;

(3) an evaluation of the person's present physical, mental, and social conditions; and

(4) a recommendation concerning the least restrictive course of services, care or treatment consistent with the person's needs.

(*c*) Subject to appropriation, the cost of this evaluation shall be borne by the department.

(*d*) Such elderly person shall have the right, at his own expense to secure an independent medical and psychological or psychiatric examination relevant to the issue involved in any hearing under this section and to present a report of his independent evaluation or the evaluator's personal testimony as evidence at the hearing.

Added by St.1982, c. 604, § 1.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

§ 22. Financial eligibility guidelines; reimbursements by elderly persons

The department shall establish, by regulation, financial eligibility guidelines which provide a procedure for reimbursement by elderly persons for all or part of cost of protective services. If the department or the designated agency determines, pursuant to section eighteen, that an elderly person who is in need of protective services has sufficient resources to pay for part or all of the cost of protective services, it shall initiate said procedures for reimbursement. If the department or designated agency determines that an elderly person does not have sufficient resources, no reimbursement for any such costs shall be charged to the elderly person.

No elderly person shall be required to reimburse the department for part or all of the cost of protective services unless he or she has been notified prior to the commencement of service provision that a reimbursement will be charged. No elderly person shall be required to reimburse the department for protective services before service provision commences.

Added by St.1982, c. 604, § 1.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

§ 23. Records; disclosure; destruction; regulations; penalties

(a) Except as otherwise provided in this section, all records containing personal data which are created, collected, used, maintained or disseminated pursuant to this chapter shall not be public records, and shall be governed by the provisions of chapter sixty-six A, the notice provisions of section sixty-three of chapter thirty and the enforcement provisions of section three B of chapter two hundred and fourteen.

(b) If the department, any designated agency, or any other agency obligated to make an assessment under this chapter determines that the allegations in a report cannot be substantiated, it shall within three months of such determination, either (i) destroy said report and any other records containing personal data created because of the receipt of said report or (ii) physically remove therefrom all personal identifiers; provided, however, that the department, the designated agency or any other agency obligated to make assessments may create and hold whatever statistical records it needs for purposes of planning and reporting, as may be prescribed by regulations adopted by the department pursuant to section two of chapter thirty. Each government agency shall promulgate regulations prescribing the manner of creating and holding its own such statistical records, and the department shall adopt such regulations for itself and any designated agency.

(c) The department, any designated agency, or any other agency obligated to make an assessment under this chapter shall inform in writing an individual, upon his request, whether he is a data subject, as that term is defined in section one of chapter sixty-six A, with respect to records created or maintained under this chapter, and if so, the department or agency shall make such data fully available to him or his authorized representative, upon his request, in a form comprehensible to him, unless doing so is prohibited or excused under the provisions of this or any other statute. In making any disclosure or information to a data subject the department or agency may remove personal identifiers relating to a third person, except where such third person is an officer or employee of a government or non-governmental department or agency obligated to make assessments under this chapter.

(d) Any agent or employee of the department, a designated agency, or any other agency obligated to make an assessment under this chapter who violates the provisions of chapter sixty-six A, as modified by this section, with respect to records created or maintained under this chapter shall be punished by a fine of not more than five hundred dollars, or, if harm shall have resulted to any one whose privacy was sought to be protected by the provision violated, by a fine of not more than one thousand dollars, and, if such agent or employee is employed by the commonwealth, he shall also be subject to administrative disciplinary action pursuant to regulations adopted by the department or agency under section two of chapter thirty A.

No provision of chapter sixty-six A, section one hundred and thirty-five of chapter one hundred and twelve or this section relating to confidential data or confidential communications shall prohibit the department or designated agency from making reports to the district attorney under subsection (b) of section sixteen or subsection (a) of section eighteen, or from providing in such reports to the district attorney any information obtained by the department or a designated agency under section fifteen or section eighteen. No person providing notification or information to a district attorney or testimony in court pursuant to the provisions of this subsection shall be liable in any civil or criminal act by reason of such action.

Nothing herein shall be construed to limit the prosecutorial power of a district attorney.

No provision of chapter sixty-six A, section one hundred and thirty-five of chapter one hundred and twelve, or any other provision of law relating to confidential data or confidential communications shall prohibit the department, by its appropriate employees, or any designated protective services agency, by its appropriate employees from testifying in any judicial proceeding pursuant to subsections (a) and (b) of section twenty, chapter two hundred and one, or chapter two hundred and nine A where the employee has acquired the information which is the subject of his testimony while conducting an assessment in accordance with section eighteen. Such testimony shall not include the identity of the reporter of abuse under section fifteen.

Added by St.1982, c. 604, § 1. Amended by St.1987, c. 566, § 11.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

1987 Legislation

St.1987, c. 566, § 11, approved Dec. 14, 1987, added subsec. (e).

§ 24. Reports

Within one hundred and twenty days following the end of each fiscal year, the department shall submit a report to the governor, the general court and the public which shall include a description of the activities of the department and all designated agencies pursuant to sections fourteen to twenty-seven, inclusive, during the preceding fiscal year. Said report shall contain statistical information about the number and types of reports received under section fifteen; the results of the assessments and evaluations conducted and the amount, type and costs of services provided under section eighteen; and information on the quality of services provided and the results of such services in terms of alleviating abuse. Said report shall identify problems that may arise in the implementation of this chapter and shall contain the recommendations of the department for action on the part of the legislature.

Added by St.1982, c. 604, § 1.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

§ 25. Rules and regulations

The secretary shall adopt and from time to time revise rules and regulations for the implementation of the provisions of sections fifteen to twenty-four, inclusive.

Added by St.1982, c. 604, § 1.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

§ 26. Powers and responsibilities of other departments or agencies

Nothing in this chapter shall be construed to be a limitation of the powers and responsibilities assigned by law to other departments or agencies.

Added by St.1982, c. 604, § 1.

1982 Enactment. St.1982, c. 604, § 1, was approved Dec. 28, 1982. Emergency declaration by the Governor was filed Dec. 29, 1982.

§ 27. Definitions applicable to sections 27 to 35

For the purpose of sections twenty-seven to thirty-five, inclusive, the following words and terms shall, unless the context requires otherwise, have the following meanings:—

APPENDIX B

651 CMR: DEPARTMENT OF ELDER AFFAIRS

651 CMR 5.00: ELDER ABUSE REPORTING AND PROTECTIVE SERVICES PROGRAM

Section

5.01: Scope and Purpose
5.02: Definitions
5.03: Functions and Responsibilities of the Department in the Administration of the Elder Protective Services Program
5.04: Functions and Responsibilities of the Protective Services Agency in Carrying Out the Elder Protective Services Program
5.05: Designation of Protective Services Agencies
5.06: Termination of Designation
5.07: Availability of Funds
5.08: Reporting Process/Intake
5.09: Who Must Report
5.10: Contents of Reports
5.11: Screening of Reports
5.12: Screening Decisions
5.13: Notification to Protective Services Agencies of Reports
5.14: Assessment of Reports
5.15: Action Upon Finding No Reportable Condition Following Assessment
5.16: Conducting a Functional Evaluation
5.17: Financial Eligibility for Protective Services
5.18: Development of a Service Plan
5.19: Obtaining Consent for Protective Services
5.20: Implementation of Service Plan with Client's Consent
5.21: Actions When Consent Not Available
5.22: Actions If Client Lacks the Capacity to Consent/Emergency Report
5.23: Actions If Client Lacks the Capacity to Consent/Non-Emergency Report
5.24: Provisions Applicable to Petitions to the Court Under M.G.L. c. 19A, ss. 20(a) or 20(b)
5.25: Follow-Up and Reassessment of Protective Services Plan
5.26: Providing Documentation of Casework and Services
5.27: Reporting to District Attorneys and Time Frames For Reporting
5.28: Financial and Administrative Responsibilities of Protective Services Agencies Under the Protective Services Program
5.29: Privacy and Confidentiality Requirements
5.30: Non-Discrimination in Service Delivery
5.31: Non-Discrimination in Employment
5.32: Protection of Clients
5.33: Affirmative Action
5.34: Waivers
5.35: Annual Report

5.01: Scope and Purpose

651 CMR 5.00 is promulgated under the authority of M.G.L. c. 19A, ss. 16(d), 16(e), 18(a) and 22 (Chapter 604 of the Acts of 1982). 651 CMR 5.00 establishes criteria and procedures for the designation, redesignation, or termination of Protective Services Agencies designated by the Department, sets forth the basis for determining those instances in which a report of Abuse or neglect may or must be made to the Department or its designated Protective Services Agencies, specifies the manner in which reports must be made, specifies the action which must be taken in receiving, investigating, and otherwise responding to such reports, including the provision of Protective Services to Elderly Persons who are determined to be Abused.

Please note that reports of abuse of elderly persons in any infirmary maintained in a town, convalescent or nursing home, rest home, charitable home for the aged or intermediate care facility for the mentally retarded, as defined in M.G.L. c. 111, s. 71 shall continue to be made to the Department of Public Health pursuant to M.G.L. c. 111, ss. 72(F) - 72(L) and shall not be made to the Department of Elder Affairs under M.G.L. c. 19A, ss. 15 and 16.

5.02: Definitions

As used in 651 CMR 5.00, unless the context requires otherwise, these terms shall have the following meanings:

Abuse. An act or omission which results in serious physical or emotional injury to an elderly person; provided, however, that no person shall be considered to be abused or neglected for the sole reason that such person is being furnished or relies upon treatment in accordance with the tenets and teachings of a church or religious denomination by a duly accredited practitioner thereof.

Adult Day Care Services shall include Social Day Care Services and Adult Day Health Services. Adult Day Care Services provide an individualized program of social activities for Eligible Elderly persons who require daytime supervision because of physical impairment or social or emotional problems that impair their capacity for self-care. Activities of social day care include: assistance with walking; assistance with mealtime activities; assistance with grooming; nutrition services including a minimum of (1) meal per day which is of suitable quality and quantity and contains at least one-third (1/3) of the current daily Recommended Dietary Allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council, as appropriate for the elder's age group; special diets must be made available if indicated by a client's Home Care Service plan; morning and afternoon snacks should be available for clients at the day care center; and client activities, including planned recreational and social activities suited to the needs of participants and designed to encourage physical and mental exercise and stimulate social interaction. Adult Day Care Services must be provided by trained and supervised staff. Adult Day Health Services are services provided by Adult Day Health Programs approved for operation by the Department of Public Welfare, and operating in accordance with 106 CMR 404.000 et seq. and whose general goal is to provide an alternative to twenty-four (24) hour a day long term institutional care through an organized program of health care and supervision, restorative services, and socialization.

Capacity to Respond to an Emergency. The capacity of a Protective Services Agency to, in an Emergency, provide Protective Services Casework; complete an assessment of an abused elderly person within twenty-four (24) hours of the receipt of the report; provide or arrange for the provision of one or more other appropriate Protective Services to an elderly person suffering from a reportable condition to alleviate the immediate danger of abuse on an emergency basis, including but not limited to a petition to the Court for an emergency order of protective services pursuant to M.G.L. c. 19A, s. 20(b), where appropriate.

Caretaker. The person responsible for the care of an elderly person, which responsibility may arise as the result of a family relationship, or by a voluntary or contractual duty undertaken on behalf of an elderly person, or may arise by a fiduciary duty imposed by law.

(a) Responsibility arising from a family relationship. A husband, wife, son, daughter, brother, or sister, or other relative of an elderly person shall be presumed to be a caretaker if (s)he is living with the elderly person on a regular basis or is otherwise acting in the role of caretaker by providing substantial assistance to the elderly person which would lead a reasonable person to believe that (s)he is acting in the role of caretaker.

(b) Responsibility arising from a fiduciary relationship imposed by law. A Guardian of the person and estate of an elderly person appointed by the Probate Court pursuant to M.G.L. c. 201 shall be a caretaker. A conservator of an elderly person appointed by the Probate Court pursuant to M.G.L. c. 201, shall be caretaker of said elderly person to the extent that (s)he must apply the assets of the estate of the elderly person to provide the necessities essential for the physical, intellectual and emotional well-being of the elderly person. The attorney-in-fact, holding a power of attorney or durable power of attorney pursuant to M.G.L. c. 201B, shall be caretaker of the elderly person granting such a power to the extent that the power of attorney or durable power of attorney requires her/him to apply the assets of the elderly person to provide the necessities essential for the physical, intellectual and emotional well-being of the elderly person.

(c) Responsibility arising from a contractual relationship. A person who is responsible for the care of an elderly person and receives monetary or personal

5.02: continued

benefit or gains as a result of a bargained for agreement with the elderly person to act as a Caretaker shall be a caretaker. A homemaker, home health aide, case manager, visiting nurse or employee of a Homemaker Service Agency, Home Care Corporation or Agency, or Visiting Nurses Association shall not be a caretaker under this definition.

(d) Responsibility arising out of the voluntary assumption of the duties of Caretaker. A person who undertakes a voluntary duty of care for an elderly person shall be presumed not to be a caretaker unless one or more of the following criteria are met by the reputed caretaker:

1. The reputed caretaker is living in the household of the elderly person;
2. The reputed caretaker is related to the elderly person and (s)he has acted or is acting by providing substantial assistance or in such a manner as to lead a reasonable person to believe that (s)he is acting as a caretaker;
3. The care being rendered by the reputed caretaker is a permanent and not temporary duration in that the reputed caretaker maintains a physical presence in the household on a regular basis.
4. The elderly person by her/his actions, statements, or behavior, indicates reliance upon the reputed caretaker for care in such a manner that a reasonable person would believe that the reputed caretaker is being relied upon by the elderly person to care for her/him;
5. The reputed caretaker, by her/his actions, statements, or behavior, indicates voluntary assumption of the obligation of caretaker in such a manner that a reasonable person would believe that the reputed caretaker is being relied upon to care for the elderly person;

Comprehensive Needs Assessment Process (CNAP). An instrument, provided by the Department, designed to assess the physical, emotional, and social functioning of prospective and current clients; determine the specific needs of each client; and facilitate the development of an appropriate service plan.

Conservator. A person who is appointed to manage the estate of a person pursuant to M.G.L. c. 201.

Conservatorship Services. Services to be provided by an individual, public agency authorized by law, or non-profit corporation, within the meaning of I.R.C. s. 501(c)(3) (1954), as amended, whose corporate charter authorizes the corporation to act as a conservator of an elderly person pursuant to the provisions of M.G.L. c. 201, whether the disabilities of such elderly person are due to advanced age, physical incapacity, mental weakness, or mental retardation to the extent and for the duration determined by the Court. Such services shall be provided only to an elderly person who, as the result of an assessment and functional evaluation by a Protective Services Agency, has been determined to be suffering from a reportable condition; is in need of Conservatorship Services; has themselves or through the order of the Court consented to the provision of such services; and is otherwise eligible to receive such services. These services shall be provided in the best interest of the elderly person and shall include taking all actions necessary in seeking and accepting appointment as Conservator; making all financial decisions regarding the real and personal property of the elderly person within the limits of the order of the Court and the laws of the Commonwealth; representing such elderly person as attorney-in-fact in legal actions as permitted by law; and doing all things necessary and appropriate to properly discharge the duties and responsibilities arising out of each such appointment as Conservator.

Counseling Services. Communication with elderly persons intended to prevent or alleviate Abuse. Interaction between a Protective Services Caseworker or other qualified person and an Eligible Elderly Person and/or Abuser intended to prevent or alleviate abuse and/or the effects of abuse.

Court. The Probate and Family Court of the Commonwealth.

Data Subject. An individual to whom personal data refers. This term shall not include corporations, corporate trusts, or other similar entities.

5.02: continued

Department. The Department of Elder Affairs.

Designation Agreement. An agreement between the Department and the Protective Services Agency providing for designation of such agency as the Protective Services Agency for a Protective Services area, which provides for such Agency to provide one or more Protective Services either directly or through sub-contract with funding through the Department, or by interagency agreement, or by use of available existing services.

Elderly Person. An individual who is sixty (60) years of age or over.

Eligible Elderly Person. An elderly person who, as a result of an assessment and functional evaluation by a Protective Services Agency, has been determined to be suffering from a reportable condition, is in need of one or more Protective Services; has themselves or through the provisions of M.G.L. c. 19A, ss. 20(a) and 20(b) consented to the provision of one or more Protective Services; and is otherwise eligible to receive one or more of such services.

Emergency. A situation in which an elderly person is living in conditions which present a substantial risk of death or immediate and serious physical or mental harm.

Emergency Report. A written or oral report, received by the Department or Protective Services Agency, from which it is determined, through screening, that a situation in which an elderly person is living presents a substantial risk of death or immediate and serious physical injury or serious mental harm to the elderly person.

Emergency Shelter is a service designed to provide temporary overnight shelter for an Eligible Elderly Person, or an Eligible Elderly Person and his/her household, who are without a home due to eviction; fire, flood, or other natural disaster; abuse, neglect or alcohol or drug dependency; or economic incapacity and/or unsafe housing conditions, including lack of fuel and/or utilities as determined by the Home Care Corporation. Home Care Corporation funded Emergency Shelter may be provided for no more than fourteen (14) calendar days during a six (6) month period at a cost not to exceed an amount specified by the Department.

Foster Care is care through an Adult Foster Care Program to provide room, board, and personal care in a family-like setting to Eligible Elderly Persons who are at risk of institutional placement. These individuals, the foster families, and the Adult Foster Care Program provider must meet the requirements set forth by the Department of Public Welfare Medical Assistance Program in 106 CMR 433.477 et seq.

Guardian. A person who has qualified as a guardian of an elderly person pursuant to M.G.L. c. 201, but shall not include a guardian ad Litem.

Guardianship Services. Services to be provided by an individual, public agency authorized by law or non-profit corporation, within the meaning of I.R.C. s. 501(c)(3) (1954), as amended, whose corporate charter authorizes the corporation to act as a guardian of an elderly person with disabilities pursuant to the provisions of M.G.L. c. 201, whether the disabilities of such an elderly person are due to mental illness, or mental retardation, to the extent and for the duration determined by the Court. Such services shall be provided only to an elderly person who, as the result of an assessment and functional evaluation by a Protective Services Agency, has been determined to be suffering from a reportable condition; is in need of Guardianship Services; lacks the capacity to consent to the provision of these services, and no other person who is authorized to consent is available or willing to consent; has no family or other person available or willing to serve in the capacity of guardian; and is otherwise eligible to receive such services. These services shall be provided in the best interests of the elderly person and shall include taking all actions necessary in seeking and accepting appointment as guardian, and shall include making personal care,

5.02: continued

medical and financial decisions for the elderly person within the limits of the order of the Court and the laws of the Commonwealth; representing such elderly person as attorney-in-fact in legal actions as permitted by law; and doing all things necessary and appropriate to properly discharge the duties and responsibilities arising out of each such appointment as guardian.

Holder. The Department and each Protective Services Agency which collects, uses, maintains or disseminates personal data as a result of performing a governmental or public function or purpose under M.G.L. c. 19A, ss. 14 - 26. Each Protective Services Agency is a Holder and subject to the provisions of 651 CMR 5.00 only with respect to personal data held under contract or arrangement with the Department under the Elder Protective Services Program.

Home Care Corporation. That unit of a designated area agency on aging charged with responsibility for the home care program; an independent Home Care Corporation organized under M.G.L. c. 180, or any other agency or organization which is supported by funds available through the Department to assure provision of home care services to elderly persons, within a designated planning and service area in the Commonwealth. A Home Care Corporation performs case management and information and referral services under the Home Care Program. A majority of the governing body of the Home Care Corporation shall be persons sixty years of age or older who reside in the cities or towns served by said Corporation. A majority of the governing body of the Home Care Corporation, except those serving the City of Boston, shall be appointed by the Councils of Aging of the cities and towns served by the Corporation. Other requirements for a Home Care Corporation are set forth in M.G.L. c. 19A, s. 4(c).

Home Health Aide Services. The provision of personal care in the home under the supervision of a registered nurse, or, if appropriate, a physical, speech, or occupational therapist. Home Health Aide Services are performed by trained personnel who assist Eligible Elderly Persons in following physicians' instructions and established plans of care. Additional services include, but are not limited to, assisting the patient with activities of daily living, exercising, taking medications ordered by a physician which are ordinarily self-administered, assisting the patient with necessary self-help skills, and reporting to the professional supervisor any changes in the patient's condition or family situation.

(a) Nursing Services. Service provided by a registered nurse, licensed practical nurse, or a nursing student under the supervision of a registered nurse, including, but not limited to the following: evaluating the nursing care needs; developing and implementing a nursing care plan; providing services that require specialized skills; observing signs and symptoms; reporting to the physician; initiating nursing procedures; giving treatments and medications ordered by the physician; teaching the patient and family, and may also include supervising other personnel.

(b) Occupational Therapy. Service provided by a registered occupational therapist (O.T.R.), a certified occupational therapy assistant (COTA), or an occupational therapy student which is supervised by a registered occupational therapist including: evaluating patient's level of function; applying diagnostic and prognostic procedures; teaching activities of daily living; observing and reporting to the physician; instructing the patient, family and health team personnel, and may also include supervising other personnel.

(c) Physical Therapy. Service provided by a registered physical therapist (R.P.T.); a physical therapy assistant (P.T.A.), or a physical therapy student which is supervised by a registered physical therapist including: evaluating patient care needs; treating patient with active and passive exercises; using specialized equipment such as packs, vibrators, etc; observing signs and reporting symptoms to the physician; instructing patient, family, and health team personnel in the use of braces, other equipment and modalities, and may also include supervising other personnel.

(d) Speech Therapy. Service provided by a qualified speech therapist, a speech therapy assistant, or a speech therapy student which is supervised by a qualified speech therapist including: evaluating patient care needs; providing rehabilitating services for speech and language disorders; observing and reporting to the physician; instructing patient, family and health care team

5.02: continued

personnel, and may also include supervising other personnel.

The Home Care Corporation shall identify appropriate clients for Home Health Services and shall make referral of such clients to the Certified Home Health Agency. A registered nurse from a Certified Home Health Agency shall complete a nursing assessment to determine the type, amount, and frequency of Home Health Services needed. A health service care plan shall be developed in coordination with the client's comprehensive service plan. The Home Care Corporation Case Manager, registered nurse, and the Certified Home Health Agency registered nurse shall agree on the integrated service plan prior to the authorization of Home Health Services. Monitoring the coordination of the home health care plan with the client's comprehensive service plan shall be the responsibility of the Home Care Corporation. The financial management of Home Health Services shall be the responsibility of the Home Care Corporation. Home Health Services shall be authorized for a maximum of six (6) months and ten (10) business days.

Homemaker Service. Homemaker Service is designed to help maintain household functioning when a Family's or eligible Elderly Person's life is threatened with disruption by long or short term illness, disability, social maladjustment, or problems which require assistance in the home to sustain independent living. Homemaker Service is concerned primarily with home management and assistance with activities of daily living and instrumental activities of daily living for a person who has a multiplicity of needs. For Homemaker Service to be authorized, an Eligible Elderly Person must have a need for one or more of the stated activities, except in the case of socialization which can only be provided in conjunction with one or more other activities. The service requires trained personnel working under agency supervision. Activities are limited to the following: shopping, menu planning, and meal preparation including special diets; light housekeeping, including but not limited to vacuuming, laundry, dusting, dry mopping, dishwashing, cleaning the kitchen and bathroom, changing beds; training in home management skills; socialization; and personal care services as defined below:

Personal care services refers to activities designed to assist functionally impaired clients to remain at home. The activities performed to assist the client may include the following: bathing, dressing, and grooming (hair care: shampoo and combing); foot care, excluding nail cutting; assistance with dentures; shaving (limited to shaving with an electric razor); assisting with bedpan routines; assisting with eating; assisting with ambulating; and assisting with transfers (excluding transfers if the Client is totally dependent).

All personal care tasks must be reviewed and approved by the Home Care Corporation Registered Nurse.

Legal Assistance. Legal advice and representation provided to an eligible elderly person by an attorney in civil matters (and to the extent feasible, counseling and other appropriate assistance by a paralegal, or law student under the supervision of an attorney), including counseling or representation by a non-lawyer where permitted by law, to Elderly Persons who are determined to be abused.

Mandated Reporter Subject to Fine. Any physician, medical intern, dentist, nurse, family counselor, probation officer, social worker, policemen, firefighter, emergency medical technician, licensed psychologist, registered physical therapist, registered occupational therapist, osteopath, podiatrist, executive director of a licensed home health agency or executive director of a homemaker service agency who has Reasonable Cause to Believe that an Elderly person is suffering from or has died as a result of a Reportable Condition.

Mandated Reporter Not Subject to Fine. Any executive director of a Home Care Corporation who has reasonable cause to believe that an elderly person is suffering or has died as the result of a reportable condition. Any homemaker, home health aide, case manager or other staff of a Home Care Corporation, licensed home health agency, or homemaker service agency who is not a licensed social worker, nurse, licensed psychologist, or family counselor, who has reasonable cause to believe that an elderly person is suffering, or has died from a

5.02: continued

reportable condition, shall be included in this category. Those occupations set forth in the previous sentence shall report such case to the executive director of the Home Care Corporation or agency.

Nutrition Project. An organization which is the recipient of a grant from an area agency on aging to provide Nutrition Services or which has the administrative authority under contract to provide Nutrition Services under Title III-C of the Older Americans Act, as amended.

Nutrition Services. Those federally funded services to be provided by Nutrition Projects to eligible elderly persons under Title III-C of the Older Americans Act, as amended, and those services provided to eligible elderly persons under the statefunded nutrition program in which certain funded costs to sponsoring agencies are paid through the Department. These services shall include, but not be limited to, congregate meals (a meal provided in a congregate setting to eligible elderly persons which meet the requirements set by the Department in 651 CMR 4.06) and home delivered meals (a meal which is furnished by a sponsoring agency to an eligible elderly person who is homebound by reason of illness, incapacitating disability, or isolation which meets the requirements set by the Department in 651 CMR 4.06).

Personal Data. Any information concerning an individual which, because of identifying number, mark or description, can be readily associated with a particular individual; provided, however, that such information is not contained in a Public Record, as defined in M.G.L. c. 4, s. 7, clause 26. Personal data shall not include intelligence information, evaluative information or criminal offender record information as defined in M.G.L. c. 6, s. 167.

Personal Data System. A system of records operated by the Department and each Protective Services Agency, which system is organized such that data are retrievable by use of the identity of the Data Subject.

Protected Person. An elderly person for whom a protector, conservator or guardian has been appointed or other protective order has been made.

Protective Order Through the Court. An order of the Court sought by petition under M.G.L. c. 19A, ss. 20(a) or (b) for the provision of one or more Protective Services for an Elderly person who is suffering from abuse, lacks the capacity to consent to such services, or requires the determination of his/her capacity to consent to such services, and as the result of a report of abuse, and subsequent assessment, evaluation, and service plan developed by the Protective Services Agency is determined to be in need of such Protective Services. A Protective Order may be sought through the Court to conduct an assessment and functional evaluation in cases where a Protective Services Agency has reasonable cause to believe that access to the allegedly abused elderly person has been barred by any person other than such allegedly abused elderly person.

Protective Services. Services which are necessary to prevent, eliminate or remedy the effects of abuse to an elderly person. Subject to appropriation, these services shall include, but not be limited to, the following: the Capacity to Respond to an Emergency, Protective Services Case Work, Legal Assistance, Counseling, Guardianship and Conservatorship, Protective Order Through the Court, the capacity to provide or arrange for Homemaker, Home-Health Aide, Transportation, Nutrition Services, Emergency Shelter, Foster Care, and Adult Day Care Services.

Protective Services Agency. A public or nonprofit private agency, corporation, board, or organization designated by the Department pursuant to M.G.L. c. 19A, s. 16 to furnish Protective Services to an eligible elderly person.

Protective Services Casework. Services provided to an elderly person by a Protective Services Agency including: conducting an assessment to determine if an elderly person is suffering from abuse; developing an evaluation of the elderly

5.02: continued

person's functional capacity, situation and resources; developing a service plan; providing or arranging for protective services to an eligible elderly person with her/his consent or with consent established in accordance with the provisions of M.G.L. c. 19A, ss. 20(a) or 20(b); providing information and referral to appropriate agencies; having the capacity to respond to an emergency; and providing counseling to elderly persons regarding the alleviation or prevention of abuse and availability of services.

Protective Services Caseworker. An employee of a Protective Services Agency who performs intake and/or assessment, functional evaluation and service planning under the Elder Protective Services Program.

Protective Services Program. The system of reporting of abuse of elderly persons and provision of Protective Services authorized to be carried out by the Department pursuant to M.G.L. c. 19A, ss. 14 - 26, subject to appropriation.

Public Records. Any document made or received by an officer or employee of the Commonwealth or of any authority established by the General Court to serve a public purpose unless it falls within the exceptions contained in M.G.L. c. 4, s. 6, clause 26.

Reasonable Cause to Believe. A basis for judgment that rests on specific facts, either directly observed or obtained from reliable sources, that supports a belief that a particular event probably took place or a particular condition probably exists.

Reportable Condition.
(a) Acts. Acts include either or both of the following:
1. Physical Abuse: The non-accidental infliction of serious physical injury to an elderly person.
2. Emotional Abuse: The non-accidental infliction of serious emotional injury to an elderly person.
(b) Omissions. Omissions include the following:
Neglect: The failure or refusal by a caretaker to provide one or more of the necessities essential for physical, intellectual, and emotional well-being, such as food, clothing, shelter, social contact, personal care, and medical care, which results in serious physical or emotional injury to an elderly person.

Serious Abuse. Reportable conditions to be reported to the District Attorney pursuant to M.G.L. c. 19A, s. 18(a) shall include, but not be limited to, the following:
(a) Death;
(b) Brain damage;
(c) Loss or substantial impairment of a bodily function or organ;
(d) Substantial disfigurement;
(e) Rape, sexual misuse or sexual exploitation.

Serious Emotional Injury. An extreme emotional conditon such as a severe state of anxiety, fear, depression or withdrawal, development of post traumatic syndrome, including but not limited to symptoms resulting from being forced to engage in sexual relations by force, threat of force or duress.

Serious Physical Injury.
(a) Death, or
(b) Fracture of a bone; extensive skin bruising; nontrivial bleeding; unreasonable decubiti; puncture wound; impairment of any system or organ; symptoms resulting from the use of medications or chemical restraints which harm the elderly person; and any other non-trivial injury including malnutrition and dehydration.

Transportation Services. Services designed to transport eligible elderly persons to and from community facilities (such as senior centers and nutrition sites), and community organizations for the purpose of socialization or applying

5.02: continued

for and receiving services, shopping, and for non-medical emergencies. Transportation Services include provision of public, private para-transit, or other forms of transportation not otherwise available pursuant to the Medicare or Medicaid programs.

5.03: Functions and Responsibilities of the Department in the Administration of the Elder Protective Services Program

(1) The Department shall, subject to appropriation, maintain a state-wide system to receive reports of the abuse of elderly persons, which shall be accessible on a twenty-four (24) hour per day basis. Further, the Department shall, subject to appropriation, develop a coordinated system of Protective Services for elderly persons suffering from a reportable condition(s) pursuant to M.G.L. c. 19A, s. 16.

(2) General Responsibilities of the Department. Subject to appropriation, the general responsibilities of the Department under the Protective Services Program shall include, but not be limited to the following:

(a) Establish a mechanism to receive reports of abuse of elderly persons on a twenty-four (24) hour per day basis.

(b) Designate, redesignate and terminate Protective Services Agencies;

(c) Continually coordinate and supervise the Protective Services Program;

(d) Adopt rules and regulations for the Protective Services Program;

(e) Continuously monitor the effectiveness of the Protective Services Program and conduct evaluative research about it;

(f) Utilize grants from federal, state, and other public and private sources to support the Protective Services Program;

(g) Screen reports of abuse of elderly persons received and refer cases to Protective Services Agencies for assessment, functional evaluation, and implementation of a service plan, where appropriate;

(h) Seek protective orders through the Court, where appropriate;

(i) Contract with Protective Services Agencies and other organizations and individuals, as appropriate, to implement the Protective Services Program;

(j) Appoint regional supervisors who shall provide monitoring, technical assistance, training, clinical advising, and assistance in responding to an emergency;

(k) Perform all other functions necessary for the administration of the Protective Services Program.

5.04: Functions and Responsibilities of the Protective Services Agency in Carrying Out the Protective Services Program

(1) Subject to appropriation, the general responsibilities of the Protective Services Agency shall include, but not be limited to, the following:

(a) Receive reports of abuse of elderly persons directly from mandated reporters subject to fine, mandated reporters not subject to fine, other persons, and the Department;

(b) Screen such reports to determine whether there is reasonable cause to believe that an elderly person is suffering from or has died from abuse, and determine whether the case is an emergency or non-emergency situation;

(c) Forward a copy of each intake form to the Department within forty-eight (48) hours of receipt of each report;

(d) Where an emergency exists, have the capacity to respond to an emergency; if no reportable condition is found, and if services are needed or requested, refer the elderly person to an appropriate agency(s);

(e) In a non-emergency, conduct and complete an assessment of the allegedly abused elderly person within seven (7) calendar days of receiving the report. The assessment shall include a visit to the residence of the elderly person who is the subject of the report and consultation with appropriate service agencies and individuals who have knowledge of the elderly person's situation. If no reportable condition is found, and if services are needed or requested, refer the elderly person to an appropriate agency(s);

(f) Where an assessment results in a finding that a reportable condition exists, complete an evaluation of the person's functional capacity, situation, and resources and develop a service plan for the provision of Protective Services which is:

5.04: continued

1. appropriate to the needs of the elderly person: and
2. utilizes the least restrictive service alternative(s);

(g) Determine the financial eligibility of the abused elderly person for purposes of collecting a sliding fee for the provision of certain Protective Services, other than Protective Services Casework, funded through the Department;

(h) If informed consent can be obtained from an elderly person suffering from a reportable condition, implement the service plan for the provision of one or more Protective Services;

(i) If informed consent for provision of Protective Services cannot be obtained due to the lack of capacity to consent by the elderly person, petition directly for a protective order through the Court pursuant to M.G.L. c. 19A, s. 20(a); provide Protective Services as ordered by the Court;

(j) Have the capacity to directly provide Protective Services Casework (including counseling);

(k) Provide or arrange for an evaluation of the capacity to consent to one or more Protective Services for an abused Elderly Person for whom a petition has been filed, or will be filed, for a Protective Order through the Court pursuant to M.G.L. c. 19A, ss. 20(a) or 20(b), or for an evaluation of mental competency and/or physical incapacity prior to petitioning for a Guardianship or Conservatorship.

(l) Report determinations of Serious Abuse to the District Attorney of the County where the abuse occurred within forty-eight (48) hours of such determination. As a result of an assessment, the Agency may, in its discretion, report threats of Serious Abuse to the District Attorney, in the same manner as determinations of Serious Abuse set forth above, where the Agency has reasonable cause to believe that the perpetrator may have the intent and capacity to carry out the threatened Serious Abuse. The Protective Services Agency and its employees shall be subject to the protections against civil or criminal liability by reason of providing notification or information to a District Attorney, or testimony in Court by reason of such report as set forth in M.G.L. c. 19A s. 23(e).

(m) Report cases in which there is reasonable cause to believe that an Elderly person has died as the result of abuse immediately to the District Attorney of the County where the abuse occurred, and to the Department.

(n) Provide or arrange for the provision of Protective Services or other services where available and in accordance with the service plan with consent of the elderly person, or upon the order of the Court pursuant to M.G.L. c. 19A, ss. 20(a) or 20(b);

(o) Contract with the Department, and other organizations and individuals, as appropriate, to implement and maintain the Protective Services Program;

(p) Perform all other functions determined by the Department to be necessary for the administration of the Protective Services Program;

(q) Comply with regulations developed by the Department to implement and maintain the Protective Services Program.

5.05: Designation of Protective Services Agencies

(1) Types of Agencies that May Be Designated. The Department may designate as a Protective Services Agency any public agency or private non-profit organization which has the capacity to implement a service plan through access to social, health and mental health services. The Department and the Protective Services Agency shall cooperate in utilizing resources and services of public and non-profit private agencies in providing Protective Services. A Protective Services Agency may be an agency whose single purpose is to administer programs for elderly persons or a multi-purpose agency with the ability and capacity to carry out the Protective Services Program.

(2) Procedures Prior to Designation. Prior to designating a Protective Services Agency, the Department may, in its discretion:

(a) Consider the views of the unit(s) of general purpose local government and area agency on aging within the Protective Services area regarding the capacity of the bidding agency or organization to carry out the responsibilities of the Protective Services Program;

(b) Conduct an on-site assessment to determine whether the Protective Services Agency or organization which is being considered has the capacity to

5.05: continued

perform all of the functions of a Protective Services Agency under the Protective Services Program;

(c) Designate a Protective Services Agency to serve more than one Protective Services area if, in its judgment, no agency or organization is qualified to serve as the Protective Services Agency in a given area.

(3) Method and Duration of Designation. The Department shall designate Protective Services Agencies for a maximum period of three (3) years. Each designation may be reviewed at least annually. Designation will be made by a letter signed by the Secretary which shall accompany the written agreement between the Department and the Protective Services Agency. The Protective Services Agency may not delegate to another agency the authority to award or administer Protective Services funds under this designation.

(4) Protective Services Geographic Areas. The Department shall designate at least one public agency or private non-profit organization to act on behalf of the Department as a Protective Services Agency for a Protective Services area. There shall be twenty-seven (27) Protective Services areas including the following cities and towns.

Cities and Towns Covered:

Region IA

Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesborough, Lee, Lenox, Monterey, Mount Washington, New Ashford, New Marlborough, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, Windsor

Region IB

Ashfield, Athol, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Monroe, Montague, New Salem, Northfield, Orange, Petersham, Phillipston, Rowe, Royalston, Shelburne, Shutesbury, Sunderland, Warwick, Wendell, Whately

Region IC

Amherst, Blandford, Chester, Chesterfield, Cummington, Easthampton, Goshen, Granville, Hadley, Hatfield, Huntington, Middlefield, Montgomery, Northampton, Pelham, Plainfield, Russell, Southampton, Southwick, Tolland, Westfield, Westhampton, Williamsburg, Worthington

Region ID

Belchertown, Chicopee, Granby, Holyoke, Ludlow, South Hadley, Ware

Region IE

Agawam, Brimfield, East Longmeadow, Hampden, Holland, Longmeadow, Monson, Palmer, Springfield, Wales, West Springfield, Wilbraham

NON-TEXT PAGE

5.05: continued

Region IIA

Ashburnham, Ashby, Ayer, Berlin, Bolton, Clinton, Fitchburg, Gardner, Groton, Hubbardston, Lancaster, Leominster, Lunenburg, Pepperell, Princeton, Shirley, Sterling, Templeton, Townsend, Westminster, Winchendon

Region IIB

Auburn, Barre, Boylston, Grafton, Hardwick, Holden, Leicester, Millbury, New Braintree, Oakham, Paxton, Rutland, Shrewsbury, West Boylston, Worcester

Region IIC

Bellingham, Blackstone, Brookfield, Charlton, Douglas, Dudley, East Brookfield, Franklin, Hopedale, Medway, Mendon, Milford, Milville, Northbridge, North Brookfield, Oxford, Southbridge, Spencer, Sturbridge, Sutton, Upton, Uxbridge, Warren, Webster, West Brookfield

Region IIIA

Beverly, Essex, Gloucester, Hamilton, Ipswich, Manchester, Rockport, Topsfield, Wenham

Region IIIB

Danvers, Marblehead, Middleton, Peabody, Salem

Region IIIC

Lynn, Lynnfield, Nahant, Saugus, Swampscott

Region IIID

Chelsea, Revere, Winthrop

Region IIIE

Everett, Malden, Medford, Melrose, North Reading, Reading, Stoneham, Wakefield

Region IIIF

Cambridge, Somerville

Region IIIG

Acton, Arlington, Bedford, Boxborough, Burlington, Carlisle, Concord, Harvard, Lexington, Lincoln, Littleton, Maynard, Stow, Wilmington, Winchester, Woburn

Region IIIH

Belmont, Brookline, Needham, Newton, Waltham, Watertown, Wellesley, Weston

Region IIIJ

Ashland, Dover, Framingham, Holliston, Hopkinton, Hudson, Marlborough, Natick, Northborough, Sherborn, Southborough, Sudbury, Wayland, Westborough

Region IIIK

Clinton, Dedham, Foxborough, Medfield, Millis, Norfolk, Norwood, Plainville, Sharon, Walpole, Westwood, Wrentham

5.05: continued

Region IIIL

Braintree, Cohasset, Hingham, Holbrook, Hull, Milton, Norwell, Quincy, Randolph, Scituate, Weymouth

Region IVA

Abington, Avon, Bridgewater, Brockton, Carver, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Kingston, Lakeville, Marshfield, Middleboro, Pembroke, Plymouth, Plympton, Rockland, Stoughton, Wareham, West Bridgewater, Whitman

Region IVB

Attleboro, Berkley, Dighton, Fall River, Freetown, Mansfield, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, Westport

Region IVC

Achusnet, Dartmouth, Fairhaven, Gosnold, Marion, Mattapoisett, New Bedford, Rochester

Region IVD

Barnstable, Bourne, Brewster, Chatham, Chilmark, Dennis, Eastham, Edgartown, Falmouth, Gay Head, Harwich, Mashpee, Nantucket, Oak Bluffs, Orleans, Provincetown, Sandwich, Tisbury, Truro, Wellfleet, West Tisbury, Yarmouth

Region V

Amesbury, Andover, Billerica, Boxford, Chelmsford, Dracut, Dunstable, Georgetown, Groveland, Haverhill, Lawrence, Lowell, Merrimack, Methuen, Newbury, Newburyport, North Andover, Rowley, Salisbury, Tewksbury, Tyngsborough, Westford, West Newbury

Region VIA

Hyde Park, South Jamaica Plain, Roslindale, West Roxbury, West Mattapan

Region VIB

Allston, Back Bay, Brighton, Fenway, Jamaica Plain, North Dorchester, Parker Hill, Roxbury, South End

Region VIC

Beacon Hill/West End, Charlestown, Chinatown, Columbia Point, Dorchester, East Boston, East Mattapan, North End, South Boston.

5.06: Termination of Designation

(1) Termination for Convenience. Either party may terminate a designation agreement without cause upon provision of written notice to the other at least sixty (60) calendar days before the effective date of such termination.

(2) Termination for Cause.
(a) In the event that either party fails to comply with the provisions of the designation agreement in whole or in part, the other party may, after specifying any alleged breach, default, or non-compliance in writing to the other party and after allowing a reasonable time, but not less than fifteen (15) calendar days for correction thereof, terminate the designation agreement by sending written notice of termination which specifies the reasons for termination to the other party, at least fifteen (15) calendar days prior to the effective date of termination.

5.06: continued

(b) If the Department determines that any non-compliance with the terms of the designation agreement on the part of the Protective Services Agency endangers life, health, and safety of recipients or applicants for services under the designation agreement, it shall terminate the designation agreement by orally notifying the Protective Services Agency of termination followed by the mailing of written notification, return receipt requested, setting forth the reasons for termination within seven (7) calendar days following the oral notification. Termination pursuant to this subsection shall take effect upon the oral notification.

(3) Continuity of Services.
(a) Upon termination of a designation agreement the Department shall designate a new Protective Services Agency in a timely manner;
(b) If necessary to ensure continuity of Protective Services in a Protective Services region, the Department may do the following for a period of up to one hundred and eighty (180) days following termination of designation:
1. Assign the responsibilities of the Protective Services Agency to another agency or organization;
2. Extend the agreement with the terminating agency;
3. Perform the responsibilities of the Protective Services Agency.

5.07: Availability of Funds

In the event that funding to the Department by state appropriation for payment for services covered pursuant to the designation agreement is reduced or terminated by the General Court of the Commonwealth of Massachusetts, so as to prevent the continued funding of all service contracts entered into under the appropriation item governing the designation agreement, the Department may terminate the designation agreement on the provision of written notice containing a specification of the reasons for termination at least thirty (30) days prior to the effective date of such termination.

5.08: Reporting Process/Intake

(1) The Department shall establish a state-wide telephone system whereby reports of alleged abuse of elderly persons shall be received on a twenty-four (24) hour per day, seven (7) day per week basis.

(2) Each Protective Services Agency shall have the capacity to receive reports of abuse.

(3) If not received during regular business hours, reports of abuse received by the Department or the Department's twenty-four (24) hour per day designee(s) shall, depending upon the judgment of the Department, be forwarded to the appropriate Protective Services Agency immediately upon receipt or the commencement of the next regular business hours of the Protective Services Agency.

(4) Oral reports received by the Department or the Department's twenty-four (24) hour per day designee(s) shall also be transcribed onto a form provided by the Department. Such form shall contain the information required in 651 CMR 5.10, and shall be forwarded to the appropriate designated Protective Services Agency as soon as possible.

(5) Reports of abuse received by a Protective Services Agency shall be transcribed onto a form provided by the Department (if not received in such a manner) and shall contain the information required in 651 CMR 5.10.

(6) Written information submitted by the reporter of Abuse to the Department, the Department's twenty-four (24) hour per day designee(s), or any Protective Services Agency shall be submitted to the appropriate Agency as soon as possible after its receipt. Such information shall be transcribed onto the form provided by the Department and become part of the case file.

5.08: continued

(7) The Protective Services Agency or the Department's twenty-four (24) hour per day designee's) shall forward a copy of the intake form to the Department within forty-eight (48) hours of their receipt of the report.

(8) At the time the report is received, the Department, the Department's twenty-four (24) hour per day designee(s) or Protective Services Agency shall advise the person reporting as follows:

(a) That if they are a mandated reporter as defined in 651 CMR 5.02 they must forward a written statement of their report of abuse to the agency to which the report was made within forty-eight (48) hours after making the verbal report;

(b) That their report is confidential and is subject to state laws and regulations regarding privacy and confidentiality;

(c) Mandated reporters subject to fine shall be informed that they will be notified in writing of the action taken in response to the report within forty-five (45) calendar days of the report. Other reporters shall be notified only upon their request. This notice shall include the following information:

1. Whether or not the information in the report constituted a reportable condition;
2. Whether or not an assessment was completed;
3. The name, address and telephone number of the Protective Services Agency conducting the assessment.

5.09: Who Must Report

(1) Mandated Reporters Subject to Fine. Mandated reporters subject to fine, as defined in 651 CMR 5.02 herein, who have reasonable cause to believe that an elderly person is suffering from or has died as a result of Abuse shall immediately make a verbal report of such information or cause a report to be made to the Department or Protective Services Agency. Such person shall within forty-eight (48) hours make a written report to the appropriate Protective Services Agency. Executive directors of licensed home health agencies and Homemaker Service agencies shall establish procedures whereby reports of alleged Abuse of an Elderly Person are forwarded to them by staff as soon as possible after they are received. Such procedures shall be in writing.

(2) Mandated Reporter Not Subject to Fine. Mandated Reporters Not Subject to Fine, as defined in 651 CMR 5.02 herein, who have reasonable cause to believe that an elderly person is suffering or has died from abuse shall report such case to the executive director of their agency. The executive director shall immediately make a verbal report of such information or cause a report to be made to the Department, the Department's twenty-four (24) hour per day designee(s) or the appropriate Protective Services Agency. Such person shall within forty-eight (48) hours make a written report to the appropriate Protective Services Agency.

(3) Other Reporters. Any other person who has reasonable cause to believe that any elderly person is suffering or has died from abuse may make such a report to the Department, the Department's twentyfour (24) hour per day designee(s), or its Protective Services Agency.

(4) Liability and Retribution Against Reporters.

(a) No employee or supervisor may discharge, demote, transfer, reduce pay, benefits, or work privileges, prepare a negative work performance evaluation, or take any other action deterimental to an employee or supervisor who files a report in accordance with the provisions M.G.L. c. 19A, ss. 15(a), 15(b), or 15(c), by reason of such report.

(b) No Mandated Reporter Subject to Fine shall be liable in any civil or criminal action by reason of such report; provided however, that such person did not perpetrate, inflict or cause said abuse.

(c) No Mandated Reporter Not Subject to Fine or other reporter of alleged abuse of an Elderly person shall be liable in any civil or criminal action by reason of such report if it was made in good faith; provided however, that such person did not perpetrate, inflict or cause said abuse.

(d) Any person making a report of abuse, pursuant to M.G.L. c. 19A, ss. 15 (a)(b) or (c) who in the determination of the Department or the

5.09: continued

District Attorney of the County where the abuse occurred may have perpetrated, inflicted, or caused said abuse may be liable in a civil or criminal action by reason of such report.

(5) The existence of a social worker-client privilege or patient-psychotherapist privilege relating to the exclusion of confidential communications shall not prohibit the filing of a report by persons subject thereto pursuant to the provisions of 651 CMR 5.09 (4)(a),(b) or (c).

NON-TEXT PAGE

5.10: Contents of Reports

Each oral and written report shall contain the following information, if known:

(1) The date and time of the report, and of the alleged abuse;

(2) The allegedly abused elderly person's
- (a) Name;
- (b) Current address;
- (c) Permanent address if different from above;
- (d) Approximate age or date of birth;
- (e) Present whereabouts;
- (f) Sex;
- (g) The names, addresses, and telephone numbers of the Elderly Person's Caretaker, or close relatives, if known;
- (h) The language spoken by the elderly person;
- (i) Information regarding the nature and extent of abuse;
- (j) Any indication of prior injury(ies), abuse or neglect and, if available, date(s) and time(s) of incident(s);
- (k) Whether in the belief of the reporter, the situation reported is one in which the elderly person is living in conditions which present a substantial risk of death or immediate and serious physical injury or serious mental harm;
- (l) Any medical treatment being received or immediately required, if known;
- (m) The name, address, and telephone number of the reporter, where they can be contacted and their relationship to the alleged abused elderly person if the reporter wishes to provide said information;
- (n) The circumstances under which the person reporting first became aware of the alleged abuse;
- (o) The action taken by the reporter, if any, to assist the abused elderly person;
- (p) A determination of whether the reporter is a Mandated Reporter as defined in 651 CMR 5.02(24) and 5.02(25) herein; and
- (q) Any other information the reporter believes to be relevant to the investigation.

(3) If known, the name, address and current whereabouts of the alleged Abuser and her/his relationship to the allegedly abused elderly person.

5.11: Screening of Reports

(1) Upon receipt of an oral or written report (whichever is received first) the intake worker shall screen the report to determine the appropriate initial response. The purpose of screening is to determine:
- (a) Whether there is reasonable cause to believe that a reportable condition exists; and
- (b) Whether or not an emergency exists.

(2) In determining 651 CMR 5.11(1)(a) and (b) the intake worker shall apply the facts alleged to the definition of Emergency set forth in 651 CMR 5.02(14), Reasonable Cause to Believe set forth in 651 CMR 5.02(38), Reportable Condition set forth in 651 CMR 5.02(39), Serious Physical Injury set forth in 651 CMR 5.02(42), and Serious Emotional Injury set forth in 651 CMR 5.02(41), Caretaker set forth in 651 CMR 5.02(3); and other appropriate provisions of 651 CMR 5.00; and shall utilize any other information obtained during screening. Such information may be obtained through discussion with the reporter, examination of Department or Protective Services Agency files and any collateral contacts necessary to provide corroborative information specific to the reported incident and the elderly person's condition.

5.12: Screening Decisions

(1) If the intake worker determines:
- (a) That there is reasonable cause to believe that a reportable condition exists; and
- (b) That an emergency exists, e.g., that an elderly person is living in conditions which present a substantial risk of death or immediate and serious

5.12: continued

physical injury or serious mental harm, then the intake worker shall immediately designate the report an Emergency Report and cause the matter to be assigned for an immediate assessment as provided in 651 CMR 5.14.

(2) If the intake worker determines based on information available in the report and obtained during screening that there is no reasonable cause to believe that a reportable condition exists, the intake form shall be placed in a file and be subject to expungement from the records of the Department and the Protective Services Agency in accordance with 651 CMR 5.29(9). Where appropriate the intake worker shall provide information and referral to the reporter regarding social, legal, health or other services which may be available to the elderly person.

(a) In cases involving reports from mandated reporters subject to fine and mandated reporters not subject to fine, the intake worker shall not determine that no reasonable cause to believe exists without:

1. Direct discussion with the reporter of Abuse, and

2. The assent of the intake worker's Protective Services Agency's supervisor or the regional supervisor of the Department.

(b) The intake worker may determine with supervisory approval that no reasonable cause to believe exists regarding a report from a nonmandated reporter, pursuant to M.G.L. c. 19A, s. 15(c), based upon:

1. A pattern of prior reports from the reporter which, upon investigation by the Department, or Protective Services Agency, have proved unsubstantial, or

2. Persuasive information obtained by the screener from reliable sources that the report cannot be substantiated.

5.13: Notification to Protective Services Agencies of Reports

(1) If the intake worker determines that the report constitutes an Emergency Report, all information on the report shall be immediately forwarded to the appropriate Protective Services Agency and/or regional supervisor.

(2) If the intake worker determines that the report constitutes a non-emergency report, all information in the report shall be forwarded to the appropriate agency as soon as possible and no later than the next business day.

5.14: Assessment of Reports

(1) An assessment of a report shall be in writing and shall determine:

(a) The identity of the allegedly abused elderly person;

(b) The nature, extent, and cause(s) of the alleged serious physical or emotional injury;

(c) The identity of the person(s) alleged to be responsible for the alleged injuries;

(d) The pertinent facts or matters which in the opinion of the Protective Services Caseworker are necessary to determine whether or not a reportable condition exists.

(2) The assessment shall include, but not be limited to the following:

(a) A visit to the residence of the elderly person who is the subject of the report for the purpose of interviewing the person about the allegations of abuse; or, if such a visit is not possible, an in-person interview with such elderly person;

b) Utilization and completion of the assessment form provided by the Department;

(c) Interviews with other members of the elderly person's household;

(d) Collateral contact with service agencies and individuals involved with the elderly person;

(e) During the home visit, or in-person interview, written notification shall be given to the elderly person, on a form provided by the Department, that an assessment is being conducted and that (s)he has a right to review the Protective Services file. If an unsuccessful attempt has been made to visit the household, or conduct an in-person interview, the written notice shall be forwarded to the allegedly abused elderly person.

5.14: continued

(3) If a caretaker or family member prevents the Protective Services Caseworker from gaining access to the elderly person who is the subject of the report, the Protective Services Caseworker shall immediately inform her/his Protective Services Agency supervisor. The Protective Services Agency supervisor shall convene a case conference with the Protective Services Caseworker and other appropriate person(s) for the purpose of determining what appropriate action may be warranted to proceed with the assessment.

(4) The assessment of all emergency reports shall be completed within twenty-four (24) hours following the receipt of the report by the Protective Services Agency. The assessment shall be in writing.

(5) The assessment of a non-emergency report shall be completed within seven (7) calendar days following the receipt of the report. The day of receipt of the report shall be day one (1) of this period.

5.15: Action Upon Finding No Reportable Condition Following Assessment

(1) If, after the assessment of an emergency report or a non-emergency report the Protective Services Caseworker determines that no reportable condition exists, the Protective Services Caseworker, with supervisory approval shall:

(a) Expunge records in accordance with 651 CMR 5.29(9) within three (3) months of such determination; and

(b) Where appropriate, the Protective Services Caseworker shall provide information and referral to the allegedly abused elderly person regarding social, health, legal, or other services which may alleviate the problem of the elderly person;

(c) Set forth the determination of no reportable condition in writing to the reporter, if required under 651 CMR 5.08(8)(c) and to the allegedly abused elderly person, if requested.

5.16: Conducting a Functional Evaluation

If after the assessment of a report the Protective Services Caseworker determines that there is reasonable cause to believe that a reportable condition exists, a functional evaluation of the elderly person shall be conducted. Such functional evaluation shall assess the functional capacity, situation and resources of the abused elderly person. It shall involve, but not be limited to, the following activities:

(1) Determination of the social, physical, and mental situation of the abused elderly person;

(2) One or more interviews with the elderly person, her/his caretaker, and members of the elderly person's household;

(3) Collateral contacts with service agencies and individuals to gather information appropriate to the determination of the service needs of the elderly person;

(4) Completion of the Department's functional evaluation form;

(5) Completion of the functional evaluation within fourteen (14) calendar days after receipt of the report by the Protective Services Agency. In cases of emergency reports, functional evaluations shall be completed within forty-eight (48) hours following the receipt of the report of abuse by the Protective Services Agency.

5.17: Financial Eligibility for Protective Services

(1) Protective Services Casework shall be provided without regard to income to eligible elderly persons.

5.17: continued

(2) An Eligible Elderly Person whose Protective Services service plan requires Home Care Services that may be provided under the Commonwealth's Home Care Program (as defined in 651 CMR 3.01(2)) shall be subject to the financial eligibility requirements set forth in 651 CMR 3.03(2), and the functional impairment level requirements set forth in 651 CMR 3.03(3), and the determination of need requirements set forth in 651 CMR 3.03(4). An Eligible Elderly Person whose Protective Services service plan requires Respite Care shall be subject to the Respite Care Program requirements set forth in 651 CMR 3.06 et seq.

(3) An Eligible Elderly Person receiving Home Care Services or Respite Care under the Sliding Fee Program as set forth in 651 CMR 3.03(2)(b) or 651 CMR 3.06(4) shall be assessed monthly fees in accordance with such sliding fee rules.

(4) An Eligible Elderly Person whose service plan requires Home Care Services or Respite Care under the Commonwealth's Home Care Program, whose annual gross income is above the sliding fee program income limits for the Home Care Program and the Respite Care Program shall pay the full cost of Home Care Services provided.

(5) Home Care Corporations shall not collect fees in excess of the monthly cost of the client's services.

(6) No Eligible Elderly Person shall be required to reimburse the Department for fees or charges for Protective Services provided, unless he or she has been notified of such fee or charge prior to the commencement of service provision. If in the judgment of the Department or the Protective Services Agency discussion of financial eligibility and/or payment of fees would have an adverse effect upon the provision of Protective Service, no such notification shall be required and no bill shall be sent to the eligible elderly person. Supervisory approval of the determination of adverse effect shall be documented in the case record. Reasonable efforts to determine financial eligibility and/or collect such fees or charges shall be made on a monthly basis following the provision of services.

(7) Home Care Corporations shall make reasonable efforts to collect such fees or charges on a monthly basis in accordance with 651 CMR 5.17 following the provision of services. All charges shall be paid by check or money order payable to the Home Care Corporation through which the service is provided. The Home Care Corporation shall remit all charges collected to the Department. The failure to pay or partial payment of monthly charges by individuals or families who receive services pursuant to 651 CMR 5.17 shall not affect the eligibility of said individuals and families for such services.

(8) Co-Payment Under Home-Delivered Meals Program. Home-delivered meals shall be provided on a per meal co-payment basis to all Eligible Elderly Persons who are financially eligible in accordance with 651 CMR 3.03(2)(f) and who need such services subject to the following requirements:

(a) Clients who receive home-delivered meals service pursuant to 651 CMR 5.17 shall be requested to pay a co-payment at a rate set at the same levels as the suggested contribution for the Title III-C of the Older Americans Act nutrition program within the service area served by the Home Care Corporation.

(b) Home Care Corporations or home-delivered meals providers shall not collect co-payments in excess of the cost per meal approved by the Department.

(c) Home Care Corporations and/or the home delivered meals providers shall use due diligence to ensure that fees are collected in accordance with 651 CMR 5.17.

(d) The failure to pay or the partial payment of such fees by clients who receive home-delivered meals pursuant to 651 CMR 5.17 shall not affect the eligibility of said clients for such services. Such services shall not be denied on this account.

5.17: continued

(9) Protective Services other than those mentioned in 651 CMR 5.17(1) through 5.17(8) shall be provided or arranged for by the Protective Services Agency subject to appropriation, and subject to the financial and other eligibility criteria of the government agency or private organization providing such service(s).

5.18: Development of a Service Plan

(1) Based on the functional evaluation and other pertinent information, the service plan shall describe, in writing, actions and services needed to eliminate or alleviate abuse. Actions and services may be provided by caseworkers, elderly persons, caretakers, relatives, friends, human service and health services professionals, and others depending on needs and availability of resources. The service plan shall include, but is not limited to, the following:

(a) Statement(s) of the major problem(s) contributing to abuse;

(b) Statement(s) of major casework objective(s) whose accomplishment will partially or completely alleviate or eliminate abuse;

(c) Statement(s) of major activities and services necessary to accomplish casework objectives. Such statement shall include a description of services already being received by the elderly person.

(2) The service plan shall utilize the least restrictive alternatives and shall be subject to consent by the abused elderly person in accordance with the provision of M.G.L. c. 19A, ss. 20(a) and/or (b).

5.19: Obtaining Consent for Protective Services

(1) A Protective Services Agency shall not provide Protective Services to an elderly person who suffers from a reportable condition and who needs such service(s) unless they have obtained one of the following:

(a) The written consent by the elderly person, or;

(b) If the elderly person lacks the capacity to consent, authorization for the provision of service(s) in accordance With M.G.L. c. 19A, ss. 20(a) or (b).

(2) The consent shall include, but not be limited to a description of all services to be provided or arranged for, including:

(a) Unit of service provided per time period (e.g., hours/weeks);

(b) Duration of services;

(c) Names and addresses of agencies to be providing services;

(d) Statement of any fee(s) assessed to the elderly person.

(3) In an emergency, service(s) may be provided with the verbal consent or by an affirmative act of the abused elderly person or guardian and the approval of the Protective Services Caseworker and her/his supervisor. The Protective Services Agency shall attempt to obtain written consent as soon as possible thereafter.

5.20: Implementation of Service Plan with Client's Consent

Upon receipt of consent from the abused elderly person or properly appointed fiduciary for the provision of one or more Protective Services, the Protective Services Caseworker shall:

(1) Provide or arrange for the provision of one or more services in accordance with the service plan, the financial eligibility of the elderly person for services funded through agencies other than the Department, and the availability of resources.

(2) Document the utilization of Protective Services by the eligible elderly person, as well as the unavailability of certain services or her/his inability to obtain certain services.

(3) Document the accomplishment of activities taken to alleviate or eliminate the abuse of the elderly person.

5.21: Actions When Consent Not Available

(1) If a Protective Services Caseworker has reasonable cause to believe that a reportable condition exists and the abused elderly person refuses to consent or withdraws consent, no Protective Services shall be provided or continued except as provided in 651 CMR 5.22 through 5.24.

(2) Upon a refusal to consent, or withdrawal of consent to Protective Services by an abused elderly person who has the capacity to consent; or upon the decision of the Court not to appoint a fiduciary of an abused elderly person under M.G.L. c. 19A, s. 20(a) or to issue an order for Protective Services, the Protective Services Caseworker shall do the following:

(a) Notify the elderly person of the availability of Protective Services should she/he decide to consent to services at a future time;

(b) Offer to the elderly person continuing Protective Services Casework;

(c) Advise the elderly person of the availability of home care and other social services in her/his area;

(d) Advise the elderly person of the availability of free legal services in her/his area;

(e) Explain the availability of M.G.L. c. 209A and other appropriate legislation to protect her/him from further abuse in family and household abuse situations.

5.22: Actions If Client Lacks the Capacity to Consent/Emergency Report

(1) The Protective Services Agency or the Department may petition the Court for an Emergency order of Protective Services under M.G.L. c. 19A, s. 20(b) specifying those services necessary to remove the condition creating the emergency if, as the result of an assessment and evaluation of an emergency report and the development of a written service plan, the Protective Services Agency or the Department has reasonable cause to believe:

(a) That a reportable condition exists;

(b) That an emergency exists, i.e., the elderly person is living in conditions which present a substantial risk of death or immediate and serious physical or mental harm;

(c) That the elderly person is in need of one or more Protective Services to remove the conditions creating the emergency;

(d) That an attempt has been made to obtain written consent for the provision of one or more Protective Services and the elderly person has not so consented; and

(e) That the elderly person has not consented because she/he lacks the capacity to consent to the provision of one or more Protective Services needed to remove the conditions creating the emergency.

(2) A member of the immediate family, or caretaker of the elderly person may also petition to the Court for such an order if they have reasonable cause to believe that the conditions set forth in 651 CMR 5.22(1)(a) through (e) exist. A member of the immediate family or caretaker is encouraged to report the alleged abuse to the Department, the Department's twenty-four (24) hour per day designee, or Protective Services Agency and seek an emergency assessment and evaluation of the situation and condition of the elderly person prior to filing a petition with the Court for an emergency order for Protective Services under M.G.L. c. 19A, s. 20(b).

(3) The petition for an Emergency order for Protective Services under M.G.L. c. 19A, s. 20(b) shall set forth the facts and attesting documentation required by the Court and be in accordance with procedures developed by the Court.

(4) If the Elderly Person who is the subject of the petition is indigent, lacks the capacity to retain counsel or waive the right to counsel, the Court shall appoint counsel and/or a guardian ad litem to represent the interest of such Elderly Person at the hearing of such emergency order.

(5) If, after a hearing the Court determines, based on the preponderance of the evidence, that the Elderly Person has been or is being abused, that an emergency exists, and that the Elderly Person lacks the capacity to consent to the provision of services, the Court may order the provision of Protective Services on an emergency basis.

5.22: continued

(6) The Court shall order only those services necessary to remove the conditions creating the emergency and shall specifically designate the authorized services in its order.

(7) The order for emergency Protective Services shall remain in effect for a period not to exceed fourteen (14) days. Said order may be extended for an additional period not to exceed fourteen (14) days if the Court finds that the extension is necessary to remove the emergency.

5.23: Actions If Client Lacks the Capacity to Consent/Non-Emergency Report

(1) The Protective Services Agency or the Department may petition the Court for the appointment of a fiduciary for purposes of consent to Protective Services under M.G.L. c. 19A, s. 20(a) and/or for an order of Protective Services under M.G.L. c. 19A, s. 20(a) if, as the result of an assessment and evaluation of a non-Emergency report and the development of a written service plan, the Protective Services Agency or the Department has reasonable cause to believe:

(a) That a reportable condition exists;

(b) That the elderly person is in need of one or more Protective Services;

(c) That an attempt has been made to obtain written consent to the provision of one or more Protective Services and the elderly person has not so consented;

(d) That either the elderly person has not consented because she/he lacks the capacity to consent to the provision of one or more Protective Services; or

(e) No legally authorized other person is available or willing to consent to the provision of one or more Protective Services.

NON-TEXT PAGE

5.23: continued

(2) The petition for appointment of a fiduciary and/or order for Protective Services shall set forth the facts and attesting documentation required by the Court and be in accordance with procedures developed by the Court. Such petition will seek the appointment of the least restrictive form of fiduciary representation that will satisfy the needs of such elderly person.

(3) The elderly person who is the subject of the petition shall have the right to be present, be represented by Counsel, present evidence and examine and cross-examine witnesses.

(4) If the Court determines that the Elderly Person lacks the capacity to retain counsel or waive the right to counsel, the Court shall appoint a guardian ad litem to represent the interests of such Elderly Person.

(5) If, after a hearing the Court determines, based on the preponderance of the evidence, that such Elderly Person has been abused, is in need of Protective Services and lacks the capacity to consent and no other person who is authorized to consent is available or willing to consent, the Court may appoint a Conservator, Guardian, or other person authorized to consent to the provision of Protective Services; provided however, that the Court shall establish the least restrictive form of fiduciary representation that will satisfy the needs of such elderly person.

(6) An order for Protective Services for an Elderly Person pursuant to M.G.L. c. 19A, s. 20(a) shall remain in effect for a period of six (6) months, unless otherwise stipulated in such order. The Court may, for good cause shown, extend an order for Protective Services. Such extension shall remain in effect for a period of six (6) months, unless otherwise stipulated in such order. The Eligible Elderly Person, the Department, or the Protective Services Agency may, for good cause shown, and at any time, petition the Court to vacate any order of the Court pursuant to M.G.L. c. 19A, s. 20(a).

5.24: Provisions Applicable to Petitions to the Court Under M.G.L. c. 19A, ss. 20(a) or 20(b)

(1) Petitions to the Court for the appointment of a Guardian, Conservator, other fiduciary, or order for Protective Services pursuant to M.G.L. c. 19A, ss. 20(a) and/or 20(b) may, if required by the Court and subject to appropriation be accompanied by an evaluation as set forth in 651 CMR 5.04(1)(k). This report may consist of the following:

(a) The name and address of the place where the elderly person is residing and of the person or agency, if any, who is providing services at present;
(b) A description of the treatment and services, if any, presently being provided to the elderly person;
(c) A statement that an appropriately licensed medical, psychological, and/or social work professional has examined said elderly person;
(d) An evaluation of the elderly person's present physical, mental and social condition;
(e) An opinion of whether, based on the evaluation of the elderly person's present physical, mental and social condition, she/he lacks the capacity to consent to the provision of Protective Services;
(f) A recommendation concerning the least restrictive course of services, care or treatment consistent with the person's needs.

(2) Such elderly person shall have the right, at her/his own expense, to secure an independent medical and psychological or psychiatric examination relevant to the issue involved in any hearing under M.G.L. c. 19A, ss. 20(a) or 20(b) and to present a report of his independent evaluation or the evaluator's personal testimony as evidence at the hearing.

(3) A fiduciary appointed pursuant to M.G.L. c. 19A, s. 20(a), or individual or organization to whom an emergency order for Protective Services under M.G.L. c.19A, s. 20(b) is directed shall cause a copy of their appointment by the Court, and the emergency order, or other order of Protective Services to be placed in the Protective Services case file of the Eligible Elderly Person as soon as possible after said appointment and order are granted.

5.24: continued

(4) The Protective Services Caseworker shall develop and implement a service plan for the provision of one or more Protective Services in accordance with the emergency order as soon as possible after M.G.L. c. 19A. ss. 20(a) or 20(b) orders are granted.

(5) Where funds are not available through appropriation from the Department to directly provide one or more Protective Services under M.G.L. c. 19A. ss. 20(a) and 20(b). the Protective Services Agency shall coordinate with and utilize existing social. health. mental health. legal and other resources to provide services under a service plan.

(6) The Protective Services Agency shall insure that the services of such persons already familiar with the elderly person shall be obtained for this purpose whenever possible.

5.25: Follow-Up and Reassessment of Protective Services Plan

(1) After the initiation of one or more Protective Services. the Protective Services Caseworker shall maintain periodic contact with the eligible elderly person to:

(a) Assess whether the services provided to the eligible elderly person are meeting her/his needs;

(b) Ascertain if the services are being provided in a manner acceptable to the eligible elderly person: and.

(c) Determine and make necessary changes in the level. amount. and/or type of services deemed appropriate by the Protective Services Caseworker which has not already been set forth in the initial service plan.

(2) After the commencement of Protective Services. reassessment of an eligible elderly person's need for services shall be accomplished at least once during the first month of service. After the initial month. each eligible elderly person's need for services shall be reassessed at least every two (2) months thereafter until such service(s) are no longer required. Any changes in the service pattern. including an increase. reduction. termination. or suspension of service other than those set forth in the initial plan. made as a result of those periodic reviews. shall be reflected in the service plan.

(3) Service Authorization. The Protective Services Agency. subject to appropriation and the availability of funding through the Department. shall issue a written service authorization to a vendor in order to initiate services to a client or to make changes in the level. amount. and/or type of services to the eligible elderly person. Such authorization to the vendor may be in effect for six (6) months. The service level and the type shall be reassessed at least every two (2) months and the authorized service shall be changed as necessary. If the circumstances of the client. as determined through the Comprehensive Needs Assessment Procedure (CNAP). are such that a six (6) month authorization is not necessary. the Protective Services Agency may restrict authorization to the vendor for a shorter period of time. For Protective Services not funded through the Department. the Protective Services Caseworker shall seek service authorization through the appropriate agency or organization in accordance with their procedures.

5.26: Providing Documentation of Casework and Services

Written documentation describing the Protective Services Caseworker's actions. contacts. and findings shall be maintained in the protective service file. These should be kept current to within five (5) business days of contacts or actions. Documentation shall include. but not be limited to:

(1) Intake information regarding reports and collateral contacts;

(2) Assessment information describing causes. incidences. nature. and extent of abuse;

5.26: continued

(3) Functional evaluation information describing social, physical, and mental status of the eligible elderly person;

(4) Descriptions of actions taken by the caseworker and/or others to alleviate or eliminate Abuse, including contacts with the eligible elderly person and others;

(5) Description of activities of other persons and agencies providing services or assistance to the eligible elderly person;

(6) Identification of sources of information concerning the eligible elderly person's social, physical and/or mental situation and other pertinent matters;

(7) Supporting documentation such as reports, evaluations, and investigations obtained from casemanagers, nurses, doctors, lawyers, psychotherapists, police officers, coroners, and other professionals;

(8) Service plan and consent for services describing services recommended, provided or arranged.

5.27: Reporting to District Attorneys and Time Frames for Reporting

(1) If the Department or its designated agency has reasonable cause to believe that an Elderly Person has died as a result of abuse, the death shall be reported immediately to the District Attorney of the County in which the abuse occurred. Written notification shall be forwarded to the District Attorney as soon as possible.

(2) If an assessment results in a determination that the Elderly Person has suffered Serious Abuse, the Department or designated agency shall report such determination to the District Attorney of the County where the abuse occurred within forty-eight (48) hours. A written report shall be forwarded to the District Attorney as soon as possible. The District Attorney may investigate and decide whether to initiate criminal proceedings.

(3) If an assessment results in a determination that the Elderly Person has suffered the threat of Serious Abuse and the Agency has reasonable Cause to Believe that the perpetrator may have the intent and capacity to carry out the threatened Serious Abuse, the Department or Protective Services Agency may, in its discretion, report such determination to the District Attorney of the County where the threatened abuse may occur as soon as possible following such determination.

(4) Release of Full Report/Personal Data. Neither the provisions of M.G.L. c. 66A regarding the confidential holding of personal data by the Department or Protective Services Agencies, M.G.L. c. 112, s. 135 regarding social worker/client privilege nor the privacy and confidentiality requirements of M.G.L. c. 19A, s. 23 shall prohibit the Department, or a Protective Services Agency, by its appropriate staff, from making full reports to the District Attorney regarding information obtained by it from the report of abuse or during the assessment, evaluation, or service provision stages of a Protective Services case involving the Serious Abuse or threat of Serious Abuse of an Elderly Person or the death of an Elderly Person resulting from abuse. The identity of the reporter of abuse shall be included in this report. Further personal data of data subjects including, but not limited to, the case file shall be released to the District Attorney upon request.

(5) The Department or the Protective Services Agency shall after the filing of such report, attempt to schedule a meeting with the District Attorney's Office in order to discuss any future action to be taken in the case.

(6) Response to Requests for and/or Production of Documents in Criminal Cases. Any party to a criminal action who seeks testimony and/or production of documents other than those documents previously released by the Department or a Protective Services Agency to the District Attorney pursuant to 651 CMR 5.27(4) shall do so by subpoena. Upon receipt of the subpoena, and prior to the date set therein for appearance or production of documents in Court, the employee of the Department or Protective Services Agency subject to such

5.27: continued

subpoena shall consult with his or her supervisor and legal counsel. The Department or Protective Services Agency may, in its discretion, move to quash such subpoena, in whole or in part if, in its opinion the testimony and/or production of documents would not be in the best interests of the Elder. If such testimony and/or production of documents is provided, it shall not include the identity of the reporter of Abuse under M.G.L. c. 19A, s. 15. This subsection shall apply to cases in which the above mentioned testimony and/or production of documents has been sought as a result of a report to the District Attorney pursuant to M.G.L. c. 19A, ss. 15(b) or 18(a) or in other criminal cases.

5.28: Financial and Administrative Responsibilities of Protective Services Agencies Under the Protective Services Program

The Protective Services Agency shall establish financial systems and procedures which comply with the provisions contained in Title 45 Code of Federal Regulations Part 74 (Administration of Grants), Subpart H (Standards for Grantee and Sub-Grantee Financial Management Systems) as well as requirements developed by the Department.

5.29: Privacy and Confidentiality Requirements

(1) Generally. All records containing Personal Data concerning elderly persons for whom a report of alleged Abuse has been made under M.G.L. c. 19A, s. 15 to the Department, the Department's twenty-four (24) hour per day designee(s), Protective Services Agencies or other agencies holding Personal Data shall be governed by M.G.L. c. 66A, the Privacy and Confidentiality Regulations of the Department, 651 CMR 2.00 et seq. and 651 CMR 5.00 shall apply to the Department, the Department's twenty-four (24) hour per day designee(s), and Protective Services Agencies as Holder(s) of Personal Data.

(2) Agreement With Holder of Personal Data. The Department shall enter into an agreement with its twenty-four (24) hour per day designee(s) and each Protective Services Agency whereby each Protective Services Agency and designee(s) agrees to act as a holder of personal data and comply with the aforementioned regulations regarding the holding of personal data as a result of performing a governmental or public function or purpose.

(3) Separate Personal Data System. Each holder of personal data under the Protective Services Program shall establish a separate Personal Data System for the implementation of its Protective Services Program in compliance with the aforementioned law and regulations regarding personal data.

(4A) Access to Personal Data by Third Parties. Each holder maintaining personal data shall not allow any agency or individual other than the employees of the Department or other holder agency under the Protective Services Program to gain access to personal data unless such access is authorized by statute or regulations, or is authorized by the Data Subject whose personal data is sought with the following exception:

Medical or psychiatric data may be made available to a physician treating a data subject upon the request of said physician, if a medical or psychiatric emergency arises Which precludes the data subject's giving approval for the release of such data, but the data subject shall be given notice of such access upon termination of the emergency.

(4B) Reports to District Attorneys/Criminal Matters

(a) Any documents provided to a District Attorney in accordance with this chapter of these regulations, which are thereafter subpoenaed from the District Attorney or otherwise requested from the District Attorney by any party to any pending criminal matter, shall be released or not released by the District Attorney solely in accordance with the applicable rules or procedures governing the District Attorney, and no notice to or consent from the Department or Protective Services Agency shall be required. The District Attorney shall make his/her best efforts to preserve the confidentiality of personal data held in such case files in accordance with M.G.L. c. 66A, the Fair Information Practices Act (FIPA), especially regarding the confidentiality of the identity of the reporter of abuse.

5.29: continued

(b) Any documents from the Department or Protective Services Agency files which are subpoenaed directly from the Department or a Protective Services Agency by any party to a criminal matter to which the Department or Protective Services Agency is not a party, shall be brought by the Department or Protective Services Agency before the trial court, at which time the Department or Protective Services Agency:

1. shall make the judge aware of the provisions of M.G.L. c. 19A, s. 23, c. 66A, s. 2, and M.G.L. c. 112, s. 135;
2. may, pursuant to 651 CMR 5.27(6), move to quash such subpoena in whole or in part if, in its opinion, the production of documents in the file would not be in the best interests of the abused elder.
3. shall seek a specific order from the judge as to the extent and manner of release by the Department or Protective Services Agency.

(5) Access to Personal Data by Data Subject. The Department, any Protective Services Agency, or any other agency obligated to make an assessment under the Protective Services Program shall inform an individual in writing, upon her/his request, whether she/he is a data subject with respect to records created or maintained under the Protective Services Program, and if so, the Department or the Protective Services Agency shall make such data fully available to her/his authorized representative upon her/his request in a form comprehensible to her/him with the following exceptions:

(a) A Holder may withhold from a data subject information which is currently the subject of an investigation if disclosure would prejudice the possibility of effective law enforcement and not be in the public interest. Information may be withheld for the time it takes for the Holder to complete its investigation and commence an administrative or judicial proceeding, or one (1) year, whichever comes first.

(b) In making a disclosure, the holder may remove personal identifiers relating to a third person, except where such third person is an officer or employee of government or agency holder of personal data under the Protective Services Program.

(6) Approval by Data Subject. The approval of the data subject which is required prior to granting access to records herein may be granted in writing or orally, including by telephone; however, the Department shall make reasonable efforts to verify the data subject's identity; and shall, if no written consent is given, file a record of any oral approval together with the personal data held.

(7A) Penalties for Violating Confidentiality Regulations. Any agent or employee of the Department, a Protective Services Agency, or any other holder agency obligated to make an assessment under the Protective Services Program who violates the confidentiality regulations set forth herein shall be subject to the following penalties, pursuant to M.G.L. c. 19A, s. 23(d):

(a) A fine of not more than five hundred ($500) dollars;

(b) A fine of not more than one thousand ($1,000) dollars if harm shall have resulted to anyone whose privacy was sought to be protected by the provision violated;

(c) If such agency or employee is employed by the Commonwealth, he shall also be subject to reprimand, suspension, dismissal, or other disciplinary action pursuant to the enforcement sanctions set forth in the Department's Privacy and Confidentiality Regulations, 651 CMR 2.05.

(7B) Defense to Civil or Criminal Action. No person providing notification or information to a District Attorney or testimony in court pursuant to M.G.L. c. 19A, s. 23 shall be liable in any civil or criminal act by reason of such action.

(7C) Testimony Involving Release of Personal Data Allowed in Certain Matters. No provision of M.G.L. c. 66A regarding the confidential holding of personal data by the Department or Protective Services Agencies, or any other provision of law relating to confidential data or confidential communications shall prohibit the Department, by its appropriate employees, or any Protective Services Agency, by its appropriate employees from testifying in any of the following types of judicial proceedings involving the client where the employee has acquired the information which is the subject of his testimony while conducting an assessment or providing Protective Services in accordance with M.G.L. c. 19A, s. 18:

5.29: continued

(a) A petition for A Protective Order through the Court, or for the appointment of a Guardian or Conservator under M.G.L. c. 19A, s. 20(a);
(b) A petition seeking An Order for Emergency Protective Services under M.G.L. c. 19A, s. 20(b);
(c) A petition seeking the appointment, discharge, or other order regarding a Guardian, Conservator, or guardian ad litem under M.G.L. c. 201;
(d) A complaint requesting protection from abuse filed under M.G.L. c. 209A, s. 3, or any subsequent Court hearing involving such complaint.

Any party other than the Department, to a legal action set forth in 651 CMR 5.29 (7C) (a), (b), (c), or (d) above who seeks testimony and/or the production of documents from the Department or any Protective Services Agency in accordance with this section shall do so by subpoena. The Department, or the Protective Services Agency may, in its discretion, move to quash such subpoena seeking such testimony or the release of such documents if, in its opinion such testimony or production of documents would be contrary to the best interests of the abused Elder(s) in question. If such testimony, and/or production of documents is provided, it shall not include the identity of the reporter of Abuse under M.G.L. c. 19A, s 15.

5.29: continued

(7D) Testimony or Release of Personal Data In Other Civil Matters. Whenever any Department or Protective Services Agency documents including that in the form of testimony are sought by compulsory legal process in any civil process other than those set forth in 651 CMR 5.29(7C), the Department or Protective Services employee shall consult with his or her supervisor and legal counsel as soon as possible following receipt of such subpoena or other compulsory process. The Department or Protective Services Agency shall not release such documents until the Department or Protective Services Agency has notified each data subject identified in the documents so that (s)he may take responsive action if so desired. Such efforts at notification may be oral or written, including oral notice by telephone. Such efforts at notification shall be documented. The Department or Protective Services Agency may, in its discretion, move to quash such subpoena, in whole or in part if, in its opinion the testimony and/or production of documents would not be in the best interests of the Elder. If such testimony and/or production of documents is provided, it shall not include the identity of the reporter of Abuse under M.G.L. c. 19A, s. 15.

(8) Access to Confidential Records During Court Proceedings.

(a) In all proceedings brought under M.G.L. c. 19A, ss. 20(a) and 20(b) or M.G.L. c. 201 in which the Department or Protective Services Agency is a party, a copy of the entire Protective Services case file, including the pertinent M.G.L. c. 19A, ss. 15(a), 15(b) or 15(c) reports, and M.G.L. c. 19A, s. 18(a) assessment and evaluation shall be made available, upon written request, to any of the following:

1. A Court appointed guardian ad litem;
2. An officer of the Court assigned by the judge;
3. An attorney for the petitioner seeking appointment as a Protector or other fiduciary under M.G.L. c. 19A, s. 20(a) or for a M.G.L. c. 19A, s. 20(b) order; for guardianship or conservatorship of the abused elderly person; an attorney for the Department, Protective Services Agency, or elderly person.

(b) The written request shall contain a statement from the requesting party that any material disclosed shall not be further duplicated nor divulged to any person not a party to the particular proceeding, unless by order of the Court. Reasonable fees for copying records shall be charged.

(c) Whenever the Department or a Protective Services Agency has reason to believe that disclosure to any individual named above of all or a portion of the Protective Services case file would be contrary to the elderly person's best interest, the Department or Protective Services Agency shall bring to the Court's attention the reason(s) for denying access.

(9) Expungement of Reports and Evaluations. The Department, Protective Services Agency, and any other agency holding personal data obligated to make an assessment under the Protective Services Program shall expunge all personal data within its control regarding a data subject where a report of alleged abuse cannot be substantiated. The holder shall, within three (3) months of such determination:

(a) Destroy said report and any other records containing personal data created because of the receipt of said report; or

(b) Physically remove therefrom all personal identifiers; provided however, that the agency holding personal data obligated to make assessment may create and hold whatever statistical records it needs for purposes of planning and reporting.

5.30: Non-Discrimination in Service Delivery

Neither the Protective Services Agency nor its subcontractors or subgrantees shall deny services to or otherwise discriminate in the delivery of services to any person who otherwise meets the eligibility criteria for the Protective Services Program, on the basis of race, color, religion, sex, age, national origin, ancestry, physical or mental handicap or because such a person is a recipient of federal, state, or local public assistance or housing subsidies. A Protective Services Agency shall comply with all applicable provisions of:

(1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.); and

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and the regulations promulgated thereunder, (45 CFR 85); and

(3) M.G.L. c. 151B, s. 4(10)

5.31: Non-Discrimination in Employment

Neither the Protective Services Agency nor its subcontractors or subgrantees shall discriminate against any qualified employee or applicant for employment because of race, color, national origin, ancestry, age, sex, religion or physical or mental handicap. They shall comply with all applicable provisions of:

(1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.); and

(2) M.G.L. c. 151B, s. 4(1); and

(3) Department of Elder Affairs, 651 CMR 8.00 - Discrimination Based on Age in Agencies and Organization in Receipt of Funds from the Department of Elder Affairs; and

(4) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and the regulations promulgated pursuant thereto (45 CFR 85).

5.32: Protection of Clients

The Protective Services Agency and its subcontractors and subgrantees shall comply with the applicable provisions of the Department of Elder Affairs' Regulations Governing the Protection of Clients Who are Participants in Research Projects (651 CMR 7.00).

5.33: Affirmative Action

The Protective Services Agency shall have in effect, maintain and adhere to a current Affirmative Action Plan which fulfills the applicable requirements of the Governor's Executive Order.

5.34: Waivers

(1) Waiver-Request by Secretary. The Secretary of the Department may, in his discretion, waive one or more of the requirements of 651 CMR 5.00 if necessary to preserve the public health, safety or welfare, and if such a waiver would not violate any applicable federal or state law or regulation. Such a waiver shall clearly identify that section of the Protective Services Program regulations to be waived; the conditions that have made such a waiver necessary; the steps that have been taken to insure that future waivers will not be necessary; the consequences to the Protective Services Program or Eligible Elderly Persons of not granting the waiver request.

(2) Other Waivers. All other requests for waivers shall be made in writing to the Secretary by the President of the Board of Directors or Chief Executive Officer of the organization making such a request and shall set forth the information required in the second sentence of 651 CMR 5.34(1).

5.35: Annual Report

The Department shall report annually on its activities and the activities of designated agencies providing Protective Services to eligible elderly persons under the Protective Services Program. Such report shall be submitted to the Governor, the General Court and the public no later than one hundred and twenty (120) days following the end of each fiscal year. The contents of such report shall include, but not be limited to:

(1) Statistical information about the number and types of reports received during the prior fiscal year;

(2) Aggregate information indicating the results of the assessments and evaluations conducted by Protective Service Agencies;

(3) Information on the types and costs of services provided under the authority of 651 CMR 5.00 during the prior fiscal year.

REGULATORY AUTHORITY

651 CMR 5.00: M.G.L. c. 19A, ss. 6, 16(d), 16(e), 18(a), 22 and 25.

NON-TEXT PAGE

APPENDIX C

The Commonwealth of Massachusetts
Executive Office of Elder Affairs
38 Chauncy Street, Boston, Mass. 02111

MICHAEL S. DUKAKIS
GOVERNOR

PAUL J. LANZIKOS
SECRETARY

PROGRAM INSTRUCTION

EOEA-PI-89- 36

TO: Designated Protective Service Agencies
Home Care Corporations

FR: Paul J. Lanzikos

RE: Standards of Practice - Protective Intake

DT: July 28, 1989

Attached are the Standards of Practice for the Intake process regarding reports of abuse or neglect of an elder. In an effort to provide written guidelines for protective service agencies as soon as possible, Elder Affairs will distribute the standards for each part of the protective casework process as they are developed. Program audits will be based on compliance with these and subsequent standards and indicators.

Elder Affairs would like to acknowledge the time and effort of the protective service caseworkers and supervisors who participated on the Standards of Practice Task Force. The experience and input of these representatives was essential in formulating a document that we feel is appropriate and applicable to the daily operations of a protective service agency.

Any questions on this PI and/or Standards should be directed to your Regional Supervisor.

PJL:MLN/cb

Commonwealth of Massachusetts

EXECUTIVE OFFICE OF ELDER AFFAIRS

ELDER PROTECTIVE SERVICES PROGRAM

STANDARDS OF PRACTICE

EXECUTIVE OFFICE OF ELDER AFFAIRS
Elder Protective Services Program

Standards of Practice - Intake

Standard I: **The designated agency has the capacity to receive reports of abuse or neglect of an elder.**

Indicator 1: The agency has a written procedure which identifies who will accept reports of abuse/neglect.

Indicator 2: The designated agency has the capacity to receive reports 24-hours-a-day, including a well-publicized telephone number to facilitate access by reporters.

Indicator 3: The Intake Worker uses the Standard Intake Form to document all reports of abuse or neglect.

Indicator 4: When a staff person (other than those identified) receives a call or information from a reporter, s/he will obtain, at least, the name and address of the elder, the nature of the reported condition and the name and telephone number of the reporter. Efforts should be made to obtain and document all information on the standard Elder Affairs Intake Form.

Indicator 5: When a report is made to a designated agency (other than the one for the area in which the elder lives), the agency shall 1) obtain the name and address of the elder, the nature of the reported condition and any additional information needed to determine if any emergency exists, 2) obtain the name and telephone number of the reporter, (3) give the caller/reporter the name, address and telephone number of the designated agency which covers the stated community, (4) transmit the obtained information to the appropriate agency no later than the next business day, and (5) in the case of an emergency (when the appropriate agency cannot be reached), call the Hotline to transmit the report to the appropriate agency.

Indicator 6: All staff of a designated agency receive training and are familiar with the reporting procedures for abuse and neglect.

Indicator 7: All staff of a designated agency communicate with sensitivity and appreciation for the difficult nature of initiating a report of elder abuse or neglect.

Standards of Practice - Intake

Standard II: In any report of suspected or actual abuse or neglect of an elder, the Intake Worker obtains the information necessary to document a reportable condition.

Indicator 1: The Intake Worker attempts to obtain the following information on the standard EOEA reporting form:

a) the date and time of the report (in the case of a Hotline report, the date and time of receipt by the Hotline and designated agency shall be included)
b) the Intake Worker and Agency name
c) the elder's:
    1) name
    2) address (permanent and temporary if appropriate)
    3) telephone number
    4) date of birth or age
    5) sex
    6) preferred language
    7) ethnicity
d) the name, address, telephone number and relationship of the elder's caregiver(s) or relatives - if known
e) the present whereabouts of the person abusing the elder and/or caregivers
f) the nature and extent of abuse or neglect
g) duration of abuse and/or neglect
h) frequency of abuse and changes over time in frequency of abuse
i) severity of abuse and/or neglect and changes in severity over time
j) any indication of prior injuries, abuse or neglect and the date(s) of incident(s)
k) the risk of further harm to the elder and if it exists, whether it is imminent
l) the risk of harm to other elders, if any in the home
m) the risk of harm to the Caseworker entering the home to complete the Assessment, if known
n) any medical treatment provided or required as a result of the abuse or neglect
o) any action/intervention provided or required immediately to ensure the elder's safety

p) the identity of the person providing such information, if other than the reporter
q) the name, address and telephone number of the reporter, their occupation and relationship to the elder
r) the circumstances under which the reporter first became aware of the abuse or neglect
s) a determination of whether the reporter is a Mandated Reporter
t) a determination of whether the elder is aware of the report
u) name(s), agency, address, telephone number and relationship of other persons knowledgeable about the elder, person(s) abusing the elder and/or caregivers
v) any other information that the reporter believes to be relevant to the investigation.

<ins>Indicator 2</ins>: If the Intake Worker is unable to obtain all of the above information at the time of the report, the Intake Worker will obtain <ins>at least</ins> the name and address of the elder, the nature of the reported condition of abuse or neglect and the name and number of the reporter.

Standards of Practice - Intake

Standard III: The Intake Worker informs each reporter of any requirements or agency policies which apply to that reporter.

Indicator 1: If the reporter is a mandated reporter (as defined in 651 CMR 5.02), then the Intake Worker informs the reporter that s/he is required to submit a written, signed report within forty-eight (48) hours of the verbal report to the designated agency.

- If the written report is not received within five (5) days, the Protective Services Caseworker assigned to the case shall make a telephone inquiry to determine if it has been sent by the reporter and document the call in the file.
- If the written report is not received within ten (10) days, a written request will be sent to the mandated reporter, a copy of which will be kept in the client's file.

Indicator 2: If a non-mandated reporter makes the report, the Intake Worker encourages him/her to give his/her name, address, telephone number and relationship to elder. The non-mandated reporter is allowed to make an anonymous report if desired.

Indicator 3: The Intake Worker informs the reporter, mandated and non-mandated, that the designated agency will make every effort to maintain the privacy of the reporter's identity, but that the agency may be required to reveal this information under certain legal circumstances.

Indicator 4: The Intake Worker (when indicated) informs reporters of their ability to obtain consultation on a case without making a report if they are not certain that they have a reportable condition and they do not reveal the identity of the elder. Reporters are informed that information discussed in consultation, which indicates a reportable condition, shall constitute a report if personal identifiers are revealed.

Indicator 5: Mandated reporters shall be informed of the Fine for not reporting, and of the civil and criminal protection provided by means of filing a report.

Indicator 6: The Intake Worker informs mandated reporters that they will be notified in writing of the action taken in response to their report within forty-five (45) days.

Standards of Practice - Intake

Standard IV: The designated agency has written procedures for the filing of a report by any Staff person (any employee or volunteer of the Home Care Corporation/designated Protective Services Agency) who has reasonable cause to believe that abuse or neglect exists.

Indicator 1: The designated agency has a system for providing consultation to Staff on possible reportable conditions.

Indicator 2: The designated agency has informed all Staff of the in-house procedures for making a report, including supervisory input if required. The procedure states that no Staff person shall be prohibited from making a report when s/he has reasonable cause to believe that a reportable condition exists.

Indicator 3: All Staff are informed that information discussed in consultation, which indicates a reportable condition, shall constitute a report if personal identifiers are revealed. If no personal identifiers are revealed, the Staff person shall exercise his/her professional judgment in determining whether or not to make a report.

Indicator 4: The designated agency has a system for resolving disagreements over the existence of a reportable condition which arise during consultation.

Indicator 5: The Staff person shall verbally transmit the report to another staff person who will function as the Intake Worker.

Indicator 6: The designated agency provides, on an on-going basis, training on the definitions and indicators of abuse and neglect.

Indicator 7: The designated agency informs the Staff Person that s/he must submit a written report within forty-eight (48) hours on the Standard, Mandated Reporter Form.

Indicator 8: The designated agency informs the Staff Person that they will be notified of the action taken within forty-five (45) days on the Standard Follow-up to Mandated Reporter Form.

Standards of Practice - Intake

Standard V: The designated agency screens the report to determine if there is reasonable cause to believe that a reportable condition may exist.

Indicator 1: The designated agency has a procedure which ensures that the report is submitted to the Protective Services Supervisor or their designated back-up Supervisor for the purpose of making screening and case assignment decisions.

Indicator 2: The Protective Services Supervisor or designated back-up Supervisor shall decide whether collateral contacts are needed to:

a) clarify/verify demographic information
b) clarify the reported conditions
c) determine whether the elder is at risk of death or immediate and serious harm

Indicator 3: Collateral contacts for the purpose of making a screening decision shall generally be limited to professionals who can provide the above information. Such contacts shall be documented under Intake notes.

Indicator 4: The Protective Services Supervisor or designated back-up Supervisor shall document the following:

a) the screening decision and rationale (emergency, non- emergency, screened out)
b) the type of abuse (if screened in)
c) the Caseworker assigned to complete the assessment
d) case status, including whether the report is an open P.S. case, closed case, or is a duplicate report on the same incident or condition
e) discussion with a Mandated Reporter concerning a decision to screen out

Indicator 5: The Protective Services Supervisor or designated back-up Supervisor shall initial or sign the screening decision and related entries. Screening decisions are made based on the information available at the time and cannot be changed.

Indicator 6: The Protective Services Supervisor or designated back-up Supervisor shall make a screening decision within forty-eight (48) hours from the time of intake and mail a copy of the completed intake to the appropriate Regional Supervisor.

Indicator 7: The designated agency has a written procedure which ensures that screened-out intakes are expunged within three (3) months.

Standards of Practice - Intake

Standard VI: **The designated agency has a system for tracking reports of abuse or neglect.**

Indicator 1: The designated agency assigns a permanent client number to each Report at the time of the intake. A separate Intake shall be completed for each elder for whom a report of abuse or neglect is made.

Indicator 2: The designated agency collects and maintains all information necessary to complete monthly Elder Affairs statistics.

APPENDIX D

The Commonwealth of Massachusetts
Executive Office of Elder Affairs
38 Chauncy Street, Boston, Mass. 02111

MICHAEL S. DUKAKIS
GOVERNOR

PAUL J. LANZIKOS
SECRETARY

PROGRAM INSTRUCTION

EOEA-PI-89-62
Reference PI-89-36

TO: Designated Protective Services Agencies
Elder Abuse Hotline

FR: Paul J. Lanzikos

DT: September 29, 1989

RE: Revised Elder Abuse Intake Form

The Elder Protective Services Program has drafted a revised Elder Abuse Intake Form with the assistance of a statewide Data Collection Task Force, comprised of Protective Services Caseworkers and Supervisors.

The purpose of the revised Intake Form is to improve intake information gathering necessary for the determination of the need for response, in accord with Protective Services Intake Standards of Practice (PI-89-36). The revised Intake Form will also allow Elder Affairs to collect and computerize data necessary for program management and reporting to the legislature.

The Protective Services Program is aware of the need to reduce paperwork to allow for increased direct service time. It is our expectation that once form revisions have been completed and staff have become familiar with these changes, that the time required by PS staff for recording and data collection will be reduced while the quality of information gathered will be improved. The Intake Form is the first of three (3) forms to be revised or developed. It is our intention that these revisions will result in the eventual elimination of the current Statistics Form. Improved information gathering will further assist PS Supervisors in screening out inappropriate reports and determining the need for emergency or non-emergency Assessments.

The issuance of the revised Intake Form will begin a six (6) month statewide field test. Following March 31, 1990, should revisions be needed, a final Intake Form will be developed and issued. Your comments and suggestions should be directed to Craig Fox, Western Regional Supervisor, EOEA, 100 North Street, Room 417, Pittsfield, MA 01201. Tel: (413) 499-4160.

Questions about the completion of the Intake Form should be directed to your Regional Supervisor or Donna Reulbach.

To obtain additional copies of this form, written requests should be submitted to Michael DiGregorio.

PJL:CRF/cb

INSTRUCTIONS FOR COMPLETING THE ELDER ABUSE INTAKE FORM (DCI 1)

The Elder Abuse Intake shall be completed in accord with PI-89-36. A separate Intake Form shall be completed for each elder alleged to be suffering from abuse or neglect.

The Intake or Hotline Worker shall complete the informational section of the Intake. The screening section shall be completed by the Protective Services Supervisor or designated backup supervisor, prior to mailing the Intake to the Protective Services Regional Supervisor. The Hotline Referral portion of the Casenotes page will be completed by the Elder Abuse Hotline for referrals to the designated Protective Services Agency. The Hotline Referral Form (HRF) will no longer be completed for non-emergency cases.

The entire Intake Form shall be completed prior to sending a copy of the form to your Regional Supervisor.

INTAKE INFORMATION SECTION

CASE NUMBER	This eight (8) digit client number is not effective until further notice by Elder Affairs. Record only the Agency Code in the first two (2) boxes. Protective Services Agency Codes are attached. Write in to the right of the case number line the case number assigned by your agency.
DATE	Enter the month - day - year that the report is called in to the Intake or Hotline Worker. For Reports received from the Elder Abuse Hotline, Designated Protective Services Agencies shall also enter the date that the Hotline received the Report in the Casenotes.
TIME	Enter the time that the report is called in and circle AM or PM. For Reports received from the Elder Abuse Hotline, Protective Services Agencies shall also enter the time the Hotline received the Report in the Casenotes.
CLIENT NAME	Record the full name of the elderly person allegedly suffering from abuse or neglect. If unknown, write in "UNKNOWN."
ADDRESS	Record the permanent address to include Apartment/Street/Box number, Town or City, and State if other than Massachusetts.

TELEPHONE	Enter client area code and phone number.
TEMPORARY RESIDENCE/ TELEPHONE	Record address and telephone of temporary residence, or the present location/whereabouts of the client, if other than the permanent address.
REPORTER NAME	Record the full name of the reporter, or note "UNKNOWN" if the reporter refuses to disclose his/her identity.
AGENCY NAME/ ADDRESS TELEPHONE	Record the address and telephone number of the reporter, or in the case of a mandated reporter, record the name of the agency represented, town and agency telephone number.
CLIENT AGE	Enter the closest approximation of the client's age in years. Do not record date of birth. If no age is available, write in "UNKNOWN."
SEX	Mark box for male or female.
REPORT SOURCE BY AGENCY	For those reporters, calling in a professional capacity, mark the box which best describes the agency or business which is represented. Code #88 "Other", should have the type of agency or company written in.
OCCUPATION/ RELATIONSHIP	Indicate the occupation of a mandated reporter by marking a single box, codes 1 through 15. Indicate the occupation or relationship of a non-mandated reporter to the client by marking a single box, codes 17 through 27. In cases where more than one occupation/ relationship may apply, mark the first box which applies. For example, when reading down the list from code 17, for an adult child (who is also the client's guardian), the code 17 guard/conservator box would be checked, while the code 20 box is left blank. In cases where a family member may be a mandated reporter, record the appropriate familial relationship box, unless the Reporter requests to be listed as a mandated reporter. Code #99 Other should have the occupation or relationship written in.

DESCRIPTION OF ALLEGED ABUSE/NEGLECT

Describe in clear, specific and factual terms allegation(s) of abuse or neglect made by the reporter. Include information about risk the Protective Services Caseworker may face in conducting the Assessment.

The following terms, which are often vague or used as labels, shall not be used in the Description of Alleged Abuse/Neglect: abuse, neglect, abuser, neglector, perpetrator or victim.

Allegations of Physical Abuse should have documented the names of persons involved in the alleged incident(s); who did what to whom (the specifics regarding where elder was hit, what was used, how many times elder was hit, intensity of blows), and where the incident(s) took place; names, addresses and phone numbers of witnesses present; date(s) and times of incidents; precipitating factors, such as alcohol use or situational stresses; injuries caused and medical treatment for past incidents; the most recent incident or reason the reporter is calling at this time. Also include the present whereabouts of persons named.

Allegations of Emotional Abuse should, in addition to those kinds of specifics noted above for physical abuse, also include a description of threats, abusive language and coercion or intimidation of the elder. Whenever possible, allegations of emotional abuse should suggest *a relationship* between abusive actions, behaviors or language *and* a resulting effect on the emotional state or functioning of the elder. For example, it is alleged a daughter began screaming at and threatening her elderly mother with nursing home placement six (6) months ago in order to extort money to support a drug habit. If the elder has become sullen, withdrawn and has stopped eating during the last several months, the behavior of the elder suggests the alleged behaviors of the elder's daughter may be adversely affecting the elder's emotional state and physical functioning and so could constitute emotional abuse.

Allegations of Sexual Abuse should include information noted above. All available specific information about the alleged incidents of sexual assault should be recorded. Note if the elder had a medical/ gynecological exam following the alleged sexual assault, the date and time of the exam, name of the examining physician and names of any police or rape crisis professionals involved.

Allegations of Neglect should include a specific, factual description of the alleged current condition of the elder. List names of all known persons providing care without which the elder would suffer serious physical injury. Note what care each person provides or provided, and specifically identify what care is not or is no longer being provided which has or is likely to result in serious physical injury.

Allegations of Death by Abuse or Neglect should include, in addition to information noted above, any statements made by the reporter suggesting that the primary cause of death was related to abuse or neglect. Facts to support or raise questions about this belief should be recorded. Names of persons with additional information may be noted, such as the physician signing the death certificate or police.

Other Allegations may be noted, such as financial exploitation or tenant-landlord conflicts.

SUMMARY OF ALLEGATIONS Check all boxes that apply. If, for example, emotional abuse and neglect are alleged, check both boxes. If no abuse or neglect is alleged to have occurred, check the Other Allegations box.

DURATION OF ABUSE/NEGLECT Check the appropriate box indicating how long the abuse and/ or neglect has been occurring. An approximation should be used before checking Unknown.

FREQUENCY OF ABUSE/NEGLECT	Check one box in each column. For example, if physical abuse is occurring weekly and is increasing in frequency (for example, from one time per week to three times per week during the last month), the Weekly and Increasing boxes would both be checked. In a case of neglect, if for example a confused elder is left alone, wanders and becomes lost on the average of one time per month and this has not changed for the last six months, the Monthly and Constant boxes would be checked. For cases involving neglect, the frequency of neglectful actions forms the basis for which boxes are checked. For cases involving both abuse and neglect, the frequency of abuse or neglectful actions is noted for the type of abuse or neglect most likely to lead to the most serious further physical injury. The Episodic box would be checked for isolated or infrequent incidents. An approximation should be used before checking the Unknown boxes.
SEVERITY OF ABUSE/NEGLECT	Check one box in each column based on the facts presented and in the opinion of the reporter. An approximation should be used before checking the Unknown boxes.
SPECIFIC ALLEGATIONS	Check all boxes that apply. Please note that the Specific Allegations section of the Intake is not intended to be used as an interviewing tool, where the Intake Worker asks if each type of abuse is present. Instead, the intent of this section is to identify in summary form, for assessment, those allegations made during the initial information gathering documented in the Description of Alleged Abuse Incidents and/or Condition of Neglect. This is intended to ensure that all types of alleged abuse are investigated, particularly in complex cases involving multiple forms of abuse and neglect.
RISK OF FUTURE ABUSE	Record whether or not further abuse is likely to occur and when, based on the facts presented and the opinion of the reporter.
MEDICAL TREATMENT	Check one box that applies; "Yes," medical treatment is or may be required immediately; "No," treatment does not appear to be needed immediately, or "Unknown." The purpose of this information is to determine the need for an emergency response.
DIAGNOSIS/ TREATMENT NEEDED	Indicate the medical condition or injury needing emergency treatment. In the absence of expert medical judgment, available information given by the reporter shall be noted.

PERSONS PROVIDING CARE	Record the names, ages, addresses and phone numbers of persons, including family, friends, neighbors, hired caretakers and fiduciaries, providing care to the elder without which the elder would be at risk of serious physical injury. The relationship of each person to the elder should also be noted. Information that is unknown may be left blank. If more than four (4) persons provide care, additional names and data may be recorded in the Case Notes section of the Intake. Agency personnel providing care should be noted under "Other" Persons Knowledgeable of the Elder.
OTHER PERSONS NAMED	Record the names, ages, addresses and phone numbers of other persons named in the description of abuse incident. This refers to persons who are not care providers, who have (allegedly) physically, emotionally or sexually abused the elder. If more than two (2) persons were named in the Description of the Alleged Abuse Incidents, additional names and data may be recorded in the Case Notes section of the Intake.
PERSONS AWARE A REPORT HAS BEEN MADE	Check all boxes which apply. If the elder is aware a report has been made, check the Elder box. Check boxes 1 through 6 for persons named above that refer to those persons providing care or are alleged to have been abusive who are aware that a report has been made. If unknown, leave boxes blank.
PREFERRED LANGUAGE	Check one or more boxes indicating the elder's preferred language(s). If the preferred language is other than English, and the elder is able to communicate in English, check both the appropriate language box and the English Spoken boxes. Note other barriers to communication, such as difficulty hearing or a speech impediment caused by stroke.
ACCESS TO ELDER/ RESPONSE	Check all boxes which apply regarding Protective Services Caseworker access to the elder for the completion of the Assessment. Other barriers to the completion of the Assessment which are present should be noted. If the elder is aware a report has been made, note the elder's willingness to accept assistance by checking the appropriate box(es).
RISK TO CASEWORKER	Check all boxes which apply regarding risks the Protective Services Caseworker may face in completing the Assessment, as indicated by the reporter. Additional, specific information should be included in the Description of Alleged Abuse Incidents and/or condition of Neglect.

MENTAL STATUS	Check one box which best describes what is believed to be the elder's current mental status. In the absence of a recent determination of a competency examination, the opinion of the Intake Worker should be based on facts presented by the reporter. The Alert/Oriented box should be checked if the elder is believed to be able to make informed judgments regarding his/her own safety, and has the capacity to consent to, or refuse protective services. If the elder has been observed to be confused and disoriented, raising a concern that s/he may not have the capacity to consent to or refuse assistance, the Confused/Disoriented box should be checked. The Unknown box may be checked if no information about the elder's mental status is available.
OTHER KNOWLEDGEABLE PERSONS	Record the names, addresses or agency names and phone numbers of other persons who may be knowledgeable of the alleged abuse or condition of neglect. For those persons who are not professionals representing an agency, note his/her relationship to the elder.

SCREENING SECTION

SCREENING DECISION	The Protective Services Supervisor shall indicate his/her screening decision by checking one box; Screened In for Assessment, Screened Out or a Multiple Report. Multiple Report refers to (A) a report received during the Assessment, or (B) a report received on an Open case which specifies the same type of abuse or neglect as indicated in the Summary of Allegations Section.
SCREENED IN STATUS	The Emergency or Non-Emergency box shall be checked indicating whether the case is screened in for emergency or non-emergency Assessment.
CASE STATUS	The status of the case shall be indicated by checking one box. In open protective cases when a report is received on the spouse of a client, the report shall be considered a New Referral if the spouse is not and was never a protective services client.

REASON FOR EMERG/NON E STATUS	The rationale for screening an Intake in for emergency or non-emergency Assessment shall be documented. Documentation shall cite specific facts or information gathered to support the screening status decision.
REASON FOR INTAKE SCREENED OUT	The reason for screening an Intake out shall be documented to justify no reasonable cause to believe that a reportable condition exists.

SIGNATURES

INTAKE WORKER AND SCREENER SIGNATURES	The Intake Worker shall print legibly his or her name, sign and date the Intake Form. The Hotline box shall also be checked when the Intake is completed by an Elder Abuse Hotline Worker. The supervisor completing the screening section shall print his or her name, sign and date the form in the space indicated "Screener".
CASE ASSIGNED TO	The Screener shall record the name of the Protective Services Caseworker, or Protective Services Back-up Caseworker, assigned to complete the Protective Services Assessment.

CASENOTES: HOTLINE REFERRAL SECTION

EMERGENCY/ NON EMERG RESPONSE	The Hotline Caseworker should check the Emergency Response box if an after hours local worker response was made. The Non-Emergency box should be checked for non-emergency Intakes.
RECIPIENT OF REFERRAL	Record the name of the Intake Worker receiving this non-emergency Intake by phone at the designated Protective Services Agency.
DATE	Enter the date the Intake was called in to the Protective Services Agency.
TIME	Enter the time the Intake was called in to the Protective Services Agency.

DATE MAILED	Enter the date the Intake Form was mailed to the Protective Services Agency.
REASON FOR NON EMERG STATUS	The rationale for determining that a case did not warrant an emergency response shall be documented. Documentation shall cite specific facts or information gathered to support the decision that no emergency response was needed. Cases in which there was an emergency response should have the Reason for Non-Emergency Status left blank.

CASENOTES

Document collateral contacts made, calls or actions taken to handle emergencies, consultation with other staff and referrals made to the Home Care Corporation or other agencies in those cases which have been screened out. Casenotes shall also include discussion with Mandated Reporters concerning a decision to screen out an Intake. Casenotes shall have noted on the left side of the page the date (and in emergencies, the time) of the contact, the name of the person contacted and agency represented. Additional Casenotes pages may be added. Casenotes should not appear on the Intake Form for contacts made after the date next to the Screener signature.

PJL:CRF/cb

PROTECTIVE SERVICE AGENCY CODES

P.S. AGENCY/HOMECARE	CODE
Baypath Senior Citizens Services, Inc.	11
Bristol Elder Services, Inc.	12
Central Boston Elder Services, Inc.	13
Chelsea/Revere/Winthrop Elder Services, Inc.	14
Coastline Elderly Services, Inc.	15
Elder Home Care Services of Worcester Area, Inc.	16
Elder Services of Berkshire County, Inc.	17
Elder Services of Cape Cod & the Islands, Inc.	18
Elder Services of the Merrimack Valley, Inc.	19
Franklin County Home Care Corp.	20
Greater Lynn Senior Services, Inc.	21
Greater Springfield Senior Services, Inc.	22
Health & Social Services Consortium, Inc.	23
Highland Valley Elder Services, Inc.	24
Holyoke/Chicopee Regional Senior Services Corp.	25
Minuteman Home Care Corporation	26
Montachusett Home Care Corp.	27
Mystic Valley Elder Services, Inc.	28
North Shore Community Mental Health	29
North Shore Elder Services, Inc.	30
Old Colony Elder Services, Inc.	31
Senior Home Care Services, Inc.	32
Senior Home Care Services Boston III, Inc.	33
Somerville/Cambridge Elder Services, Inc.	34
South Shore Elder Services, Inc.	35
Southwest Boston Senior Services, Inc.	36
Tri-Valley Elder Services, Inc.	37
West Suburban Elder Services, Inc.	38

CLIENT NAME : ____________________ PHONE: (   ) ____________

ADDRESS: ____________________

____

[illegible]

TIME: ________ AM PM

TEMP RESIDENCE: ____________________ PHONE: (   ) ____________

CLIENT [illegible]

REPORTER NAME : ____________________

AGENCY NAME/ REPORTER ADDRESS: ____________________ PHONE: (   ) ____________

[illegible]

[illegible]

DESCRIPTION OF ALLEGED ABUSE INCIDENTS AND/OR CONDITION OF NEGLECT:

Include names, dates, times and specific facts

____

____

____

____________________ Continue on back __

Elder Abuse Intake Form

Executive Office of Elder Affairs
Commonwealth of Massachusetts

DCI 1-1/89

DESCRIPTION OF ALLEGED ABUSE/ NEGLECT CONT: ____________________

SUMMARY OF ALLEGATIONS
Check all that apply

1 ☐ Physical Abuse
2 ☐ Emotional Abuse
3 ☐ Sexual Abuse
4 ☐ Neglect
5 ☐ Death by Abuse or Neglect
6 ☐ Other Allegations

FREQUENCY OF ABUSE/ NEGLECT

☐ Daily
☐ Weekly
☐ Monthly
☐ Episodic
☐ Unknown

☐ Increasing
☐ Decreasing
☐ Constant
☐ Unknown

DURATION OF ABUSE/ NEGLECT

☐ First Incident
☐ 1 - 3 weeks
☐ 1 - 6 months
☐ 7 - 11 months
☐ 1 - 2 years
☐ 3 - 5 years
☐ 6 - 10 years
☐ More than 10 years
☐ Unknown

SEVERITY OF ABUSE/ NEGLECT

☐ Life Threatening
☐ Risk of Serious Injury
☐ Risk of Minor Injury
☐ Unknown

☐ Increasing
☐ Decreasing
☐ Constant
☐ Unknown

SPECIFIC ALLEGATIONS

Serious Physical Abuse

☐ Bruises, Welts
☐ Sprains, Dislocations
☐ Burns, Scalding
☐ Abrasions, Lacerations
☐ Wounds, Cuts, Punctures
☐ Broken Bones
☐ Internal Injuries
☐ Sexual Assault
☐ Injury to Vital Organs/Head
☐ Other Unspecified Injuries

Emotional Abuse

☐ Sleep Disturbance
☐ Worried, Anxious
☐ Irritable, Easily Upset
☐ Change in Eating Habits
☐ Loss of Interest
☐ Fear of Retribution
☐ Suicidal Talk/Wishes
☐ Shaking, Frequent Crying
☐ Other: ____________________

Abusive Actions (emotional and physical)

☐ Insulted/ Swore/ Yelled at Victim
☐ Threatened, Coerced
☐ Pushed, Shoved
☐ Attempted to Harm
☐ Threw Objects at Victim
☐ Pushed, Grabbed Victim
☐ Struck or Kicked Victim
☐ Threatened Victim with Weapon
☐ Injured Victim with Weapon
☐ Forced Alcohol/Meds/Substance Use
☐ Physically Restrained
☐ Choked
☐ Isolated/Confined
☐ Locked In/Out of Home/Room
☐ Forced from Home
☐ Mutual Abuse
☐ Other: ____________________

Serious Neglect

☐ Filth, Vermin, Squalor
☐ Skin Rashes
☐ Sores
☐ Malnourishment

Serious Neglect Continued

☐ Dehydration
☐ Inappropriate Clothing
☐ Fecal/Urine Odor
☐ Untreated Medical Condition
☐ Disoriented/Confused/Becomes Lost
☐ Freq Falls with Injuries
☐ Homeless/Transient Living Conditions
☐ Other: ____________________

Neglectful Actions: Caregivers Withhold Or Fail to Provide

☐ Adequate Food
☐ Adequate Personal Care
☐ Adequate Supervision
☐ Prescribed Medication
☐ Medical Equipment or Aids
☐ Access to Medical Treatment
☐ Shelter
☐ Adequate Heat
☐ Utilities: Elec/Water
☐ Other: ____________________

Physical Environmental Problems

☐ Disrepair
☐ Level of Cleanliness
☐ Architectural Barriers
☐ Kitchen/Bathroom Facilities
☐ Living/Sleeping Area
☐ Utilities
☐ Fire Safety
☐ Pest Control
☐ Other: ____________________

Other Allegations

☐ Mismanagement of Income
☐ Misappropriation of Income
☐ Extortion
☐ One-time Assault by Unknown Assailant
☐ Marital Dispute
☐ Homeless
☐ Legal Problem
☐ Landlord/Tenant Dispute
☐ Community Discomfort with Life-style
☐ Other: ____________________

RISK OF FUTURE ABUSE OR SERIOUS INJURY/ WHEN: ____________________

IS MEDICAL TREATMENT REQUIRED IMMEDIATELY: ☐ YES ☐ NO ☐ UNKNOWN

TENTATIVE DIAGNOSIS/ TREATMENT NEEDED: ____________________

DCI 1-3/89

PERSONS PROVIDING CARE:

1 NAME: ______________ AGE: ____ RELATIONSHIP: __________

ADDRESS: ____________________ PH: (   ) __________

2 NAME: ______________ AGE: ____ RELATIONSHIP: __________

ADDRESS: ____________________ PH: (   ) __________

3 NAME: ______________ AGE: ____ RELATIONSHIP: __________

ADDRESS: ____________________ PH: (   ) __________

4 NAME: ______________ AGE: ____ RELATIONSHIP: __________

ADDRESS: ____________________ PH: (   ) __________

OTHER PERSONS NAMED IN THE DESCRIPTION OF ALLEGED ABUSE/ NEGLECT:

5 NAME: ______________ AGE: ____ RELATIONSHIP: __________

ADDRESS: ____________________ PH: (   ) __________

6 NAME: ______________ AGE: ____ RELATIONSHIP: __________

ADDRESS: ____________________ PH: (   ) __________

Preferred Language

- ☐ Cape Verdean Creole
- ☐ Chinese
- ☐ English
- ☐ Finnish
- ☐ French
- ☐ Greek
- ☐ Haitian Creole
- ☐ Italian
- ☐ Khmer (Cambodian)
- ☐ Lao
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Sign Language
- ☐ Spanish
- ☐ Other: __________
- ☐ Unknown

☐ English Spoken

Communication Barriers:

____

____

____

PERSONS AWARE A REPORT HAS BEEN MADE

☐ Elder Persons: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

ACCESS TO ELDER

- ☐ Elder Accessible
- ☐ See Outside of Home
- ☐ Access By Phone Only
- ☐ Person Barring Access
- ☐ Whereabouts Unknown

☐ Other barriers: ____________________

☐ Unknown

ELDER'S RESPONSE

- ☐ Wants Assistance
- ☐ Refusing Visit
- ☐ Fears Retribution
- ☐ No Response
- ☐ Unknown

RISK TO CASEWORKER

- ☐ Guns/Weapons in Home
- ☐ Easily Agitated
- ☐ History of Assaults on Others
- ☐ Psychiatric History
- ☐ Alcohol/Drug Abuse History
- ☐ High Crime Area
- ☐ Dogs
- ☐ Other: __________
- ☐ Unknown

MENTAL STATUS

- ☐ Alert/ Oriented
- ☐ Confused/ Disoriented
- ☐ Unknown

DCI 1-4/89

OTHER PERSONS KNOWLEDGEABLE OF THE ELDER

Name	Agency/Rel	Address	Phone

To Be Completed by the Protective Services Supervisor or Designated Backup Supervisor

SCREENING DECISION

1 ☐ Screened In 2 ☐ Screened Out 3 ☐ Multiple Report

SCREENED IN STATUS

1 ☐ Emergency
2 ☐ Non Emergency

SCREENED OUT STATUS

1 ☐ No Reportable Condition
2 ☐ Presently Open

CASE STATUS

1 ☐ New Referral 2 ☐ Open PS Case 3 ☐ Closed PS Case

REASON FOR EMERGENCY OR NON-EMERGENCY STATUS: ____________________

REASON FOR INTAKE SCREENED OUT: ____________________

INTAKE WORKER ____________________ ☐ Hotline ____________________ Signature ________ Date

SCREENER ____________________ ____________________ Signature ________ Date

DCI 1-5/89

COLLATERAL CONTACTS/EMERGENCY RESPONSE/REFERRAL CASENOTES:

HOTLINE REFERRAL

Hotline
Use
Only

☐ Emergency Response (HRF Encl) ☐ Non-Emergency

Recipient of Referral: ______

Date: ______ Time: ______ Date Mailed: ______

Reason for Non-Emergency Status: ______

APPENDIX E

EXECUTIVE OFFICE OF ELDER AFFAIRS

Home Care Corporations/Area Agencies on Aging
Index

	Page	Region
*Baypath Senior Citizens Services, Inc	1	IIIJ
*Bristol Elder Services, Inc	1	IVB
Central Boston Elder Services, Inc	1	VI
*Chelsea/Revere/Winthrop Elder Services	1	IIID
*Coastline Elderly Services, Inc	1	IVC
*Commission on Affairs of the Elderly	1	VI
Elder Home Care Services of the Worcester Area, Inc	2	II
*Elder Services of Berkshire County, Inc	2	IA
*Elder Services of Cape Cod and the Islands, Inc	2	IVD
*Elder Services of the Merrimack Valley, Inc	2	V
*Franklin County Home Care Corporation	2	IB
*Greater Lynn Senior Services, Inc	2	IIIC
*Greater Springfield Senior Services, Inc	3	IE
*Health & Social Services Consortium, Inc. (HESSCO)	3	IIIK
*Highland Valley Elder Services, Inc	3	IC
*Holyoke/Chicopee Regional Senior Services Corp	3	ID
*Minuteman Home Care Corporation	3	IIIG
Montachusett Home Care Corporation	3	II
*Mystic Valley Elder Services, Inc	4	IIIE
*North Shore Elder Services, Inc	4	IIIB
Old Colony Elderly Services, Inc	4	IVA
*Old Colony Planning Council	4	IVA
*Region II Area Agency on Aging, Inc	4	II
*Senior Home Care Services, Inc	4	IIIA
Senior Home Care Services Boston III, Inc	5	VI
*Somerville/Cambridge Elder Services, Inc	5	IIIF
*South Shore Elder Services, Inc	5	IIIL
Southwest Boston Senior Services, Inc	5	VI
Tri-Valley Elder Services, Inc	5	II
*West Suburban Elder Services, Inc	5	IIIH

*Area Agency on Aging

(REV: 10/89 MF)

EXECUTIVE OFFICE OF ELDER AFFAIRS
Home Care Corporations/Area Agencies on Aging

*Baypath Senior Citizens
Services, Inc.
P.O. Box 2625
Central Station
Framingham, MA 01701
(508) 620-0840; Toll Free: (800) 448-0110
Maria Steele, President
Donald Medd, Exec. Director

Ashland, Dover, Framingham, Holliston, Hopkinton, Hudson, Marlborough, Natick, Northborough, Sherborn, Southborough, Sudbury, Wayland, and Westborough.

*Bristol Elder Services, Inc.
182 North Main Street
Fall River, MA 02720
(508) 675-2101
Ethel S. O'Brien, Chairman
Carol Nagle, Director

Attleboro, Berkley, Dighton, Fall River, Freetown, Mansfield, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, and Westport.

Central Boston Elder Services, Inc.
812 Huntington Avenue
Boston, MA 02115
(617) 277-7416
Lois Hunter, President
Paul McLaughlin, Director

Allston, Back Bay, Brighton, Fenway, Jamaica Plain, North Dorchester, Parker Hill, Roxbury, and South End.

*Chelsea/Revere/Winthrop
Elder Services
300 Broadway
P.O. Box 189
Revere, MA 02151
(617) 286-0550
Edward Greenberg, President
James P. Cunningham, Jr., Director

Chelsea, Revere, and Winthrop.

*Coastline Elderly Services, Inc.
106 Huttleston Avenue
Fairhaven, MA 02719
(508) 999-6400
Nancy Salander, President
Charles Sisson, Executive Director

Acushnet, Dartmouth, Fairhaven, Gosnold, Marion, Mattapoisett, New Bedford, and Rochester.

*Commission on Affairs of the Elderly (Boston)
One City Hall Square
Room 271
Boston, MA 02201
(617) 725-4366; Hot Line: 725-4646
TDD: (725-4587)
Diane Watson, Commissioner

*Area Agency on Aging

Home Care Corporations/Area Agencies on Aging

Elder Home Care Services of Worcester Area, Inc. 1241 Main Street Worcester, MA 01603 (508) 756-1545 James Fanale, M.D., President Lois Green, Director	Auburn, Barre, Boylston, Grafton, Hardwick, Holden, Leicester, Millbury, New Braintree, Oakham, Paxton, Rutland, Shrewsbury, West Boylston, and Worcester.
*Elder Services of Berkshire County, Inc. 100 North Street Pittsfield, MA 01201 (413) 499-1353; Toll Free: (800) 292-5011 Francis Wilson, President Catherine May, Director	Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesborough, Lee, Lenox, Monterey, Mount Washington, New Ashford, New Marlborough, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, and Windsor.
*Elder Services of Cape Cod and the Islands, Inc. 68 Route 134 South Dennis, MA 02660 (508) 394-4630; Toll Free: (800) 352-7178 Mrs. Linnea Gordon, President Sarah Fogerty, Director	Barnstable, Bourne, Brewster, Chatham, Chilmark, Dennis, Eastham, Edgartown, Falmouth, Gay Head, Harwich, Mashpee, Nantucket, Oak Bluffs, Orleans, Provincetown, Sandwich, Tisbury, Truro, Wellfleet, West Tisbury, and Yarmouth.
*Elder Services of the Merrimack Valley, Inc. 420 Common Street Lawrence, MA 01840 (508) 683-7747; Toll Free: (800) 892-0890 Leon Summers, Ph.D., President Rosanne DiStefano, Director	Amesbury, Andover, Billerica, Boxford, Chelmsford, Dracut, Dunstable, Georgetown, Groveland, Haverhill, Lawrence, Lowell, Merrimack, Methuen, Newbury, Newburyport, North Andover, Rowley, Salisbury, Tewksbury, Tyngsborough, Westford, and West Newbury.
*Franklin County Home Care Corp. Central Street Turner Falls, MA 01376 (413) 863-9565 Paul Douglas, President Patricia Kerrins, Director	Ashfield, Athol, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Monroe, Montague, New Salem, Northfield, Orange, Petersham, Phillipston, Rowe, Royalston, Shelburne, Shutesbury, Sunderland, Warwick, Wendell, and Whately.
*Greater Lynn Senior Services, Inc. 8 Silsbee Street Lynn, MA 01901 (617) 599-0110 Thomas Lowe, President Vince Lique, Director	Lynn, Lynnfield, Nahant, Saugus, and Swampscott.

*Area Agency on Aging

Home Care Corporations/Area Agencies on Aging

*Greater Springfield Senior Services, Inc.
66 Industry Avenue
Springfield, MA 01104
(413) 781-8800
William G. Sheehan, President
Patricia K. Clark, Director

Agawam, Brimfield, East Longmeadow, Hampden, Holland, Longmeadow, Monson, Palmer, Springfield, Wales, West Springfield, and Wilbraham.

*Health & Social Services Consortium, Inc. (HESSCO)
IGO Building
Carpenter Street
Foxborough, MA 02035
(508) 769-7440; 543-2611; Toll Free: (800) 462-5221
Barbara Cade, President
Mary Jean McDermott, Director

Canton, Dedham, Foxborough, Medfield, Millis, Norfolk, Norwood, Plainville, Sharon, Walpole, Westwood, and Wrentham.

*Highland Valley Elder Services, Inc.
320 Riverside Drive
Northampton, MA 01060
(413) 586-2000;
Toll Free: (800) 322-0551
Edward J. Lawton, Jr., President
Robert V. Gallant, Director

Amherst, Blandford, Chester, Chesterfield, Cummington, Easthampton, Goshen, Granville, Hadley, Hatfield, Huntington, Middlefield, Montgomery, Northampton, Pelham, Plainfield, Russell, Southampton, Southwick, Tolland, Westfield, Westhampton, Williamsburg, and Worthington.

*Holyoke/Chicopee Regional Senior Services Corporation
198 High Street
Holyoke, MA 01040
(413) 538-9020;
Hot Line: (800) 462-2301
Elizabeth O'Connell, President
Priscilla L. Chalmers, Director

Belchertown, Chicopee, Granby, Holyoke, Ludlow, South Hadley, and Ware.

*Minuteman Home Care Corporation
24 Third Avenue
Burlington, MA 01803
(617) 272-7177
Malcolm Thompson, President
Joan Butler-West, Director

Acton, Arlington, Bedford, Boxborough, Burlington, Carlisle, Concord, Harvard, Lexington, Lincoln, Littleton, Maynard, Stow, Wilmington, Winchester, and Woburn.

Montachusett Home Care Corporation
545 Westminster Street
Fitchburg, MA 01420
(508) 345-7312
Margaret Kielty, President
Eleanor Gilmartin, Director

Ashburnham, Ashby, Ayer, Berlin, Bolton, Clinton, Fitchburg, Gardner, Groton, Hubbardston, Lancaster, Leominster, Lunenberg, Pepperell, Princeton, Shirley, Sterling, Templeton, Townsend, Westminster, and Winchendon.

*Area Agency on Aging

Home Care Corporations/Area Agencies on Aging

*Mystic Valley Elder Services, Inc. 661 Main Street, Suite 110 Malden, MA 02148 (617) 324-7705 M. Kent Fletcher, President Daniel O'Leary, Director	Everett, Malden, Medford, Melrose, North Reading, Reading, Stoneham, and Wakefield.
*North Shore Elder Services, Inc. 152 Sylvan Street Danvers, MA 01923 (508) 750-4540 TDD: (744-4184) M. Jeanne Ahern, President Janet McAveeney, Director	Danvers, Marblehead, Middleton, Peabody, and Salem. **Designated Protective Service Agency** Health & Education Services, Inc. 162 Federal Street Salem, Massachusetts 01970 Phone: 508-745-2440 or 535-6220
*Old Colony Elderly Services, Inc. 144 Main St./P.O. Box 1586 Brockton, MA 02403 (508) 584-1561; 697-3338; 586-3700; Toll Free: (800) 242-0246 Beatrice Calderwood, President Edward T. Donovan, Director	Abington, Avon, Bridgewater, Brockton, Carver, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Kingston, Lakeville, Marshfield, Middleborough, Pembroke, Plymouth, Plympton, Rockland, Stoughton, Wareham, West Bridgewater, and Whitham.
*Old Colony Planning Council 70 School Street Brockton, MA 02401 (508) 583-1833 Robert Smith, President Daniel M. Crane, Director	Abington, Avon, Bridgewater, Brockton, Carver, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Kingston, Lakeville, Marshfield, Middleborough, Pembroke, Plymouth, Plympton, Rockland, Stoughton, Wareham, West Bridgewater, and Whitham.
*Region II Area Agency on Aging, Inc. 1128 Main Street Holden, MA 01520 (508) 829-5364; Toll Free: (800) 322-3032 Lorraine Remby, President Catherine Fellenz, Exec. Director	See Worcester, Montachusett and Tri-Valley.
*Senior Home Care Services, Inc. 2 Main Street Gloucester, MA 01930 (508) 281-1750 Shirley Needham, President Guntis Licis, Director	Beverly, Essex, Gloucester, Hamilton, Ipswich, Manchester, Rockport, Topsfield, and Wenham.

*Area Agency on Aging

Home Care Corporations/Area Agencies on Aging

Senior Home Care Services
Boston III, Inc.
600 Washington Street (6th Floor)
P.O. Box 29
Boston, MA 02112
(617) 451-6400
Henrietta Murray, President
Terry Ann Lunt, Director

Beacon Hill/West End, Charlestown, Chinatown, Columbia Point, Dorchester, East Boston, East Mattapan, North End, and South Boston.

*Somerville/Cambridge Elder Services, Inc.
One Davis Square
Somerville, MA 02144
(617) 628-2601; 2602
TDD: (628-1705)
Mary Mullen, President
John F. O'Neill, Director

Cambridge and Somerville.

*South Shore Elder Services, Inc.
639 Granite Street
Braintree, MA 02184
(617) 749-6832; 383-9790; 848-3910
June Williams, President
Susan Young, Director

Braintree, Cohasett, Hingham, Holbrook, Hull, Milton, Norwell, Quincy, Randolph, Scituate, and Weymouth.

Southwest Boston Senior Services, Inc.
23 Florence Street
Roslindale, MA 02131
(617) 325-6565; 6566
Harry Douglas, President
Eileen Cohen-Bogle, Director

Hyde Park, South Jamaica Plain, Roslindale, West Roxbury, and West Mattapan.

Tri-Valley Elder Services, Inc.
284 Worcester Street
Southbridge, MA 01550
(508) 764-2501
Toll Free 1-800-462-5225
William Walker, President
Bernard Gagnon, Director

Bellingham, Blackstone, Brookfield, Charlton, Douglas, Dudley, East Brookfield, Franklin, Hopedale, Medway, Mendon, Milford, Milville, Northbridge, North Brookfield, Oxford, Southbridge, Spencer, Sturbridge, Sutton, Upton, Uxbridge, Warren, Webster, and West Brookfield.

*West Suburban Elder Services, Inc.
Parker Office Building
124 Watertown Street
Watertown, MA 02172
(617) 926-4100
David Rockwell, President
Carol Oram, Director

Belmont Brookline, Needham, Newton, Waltham, Watertown, Wellesley, and Weston.

*Area Agency on Aging

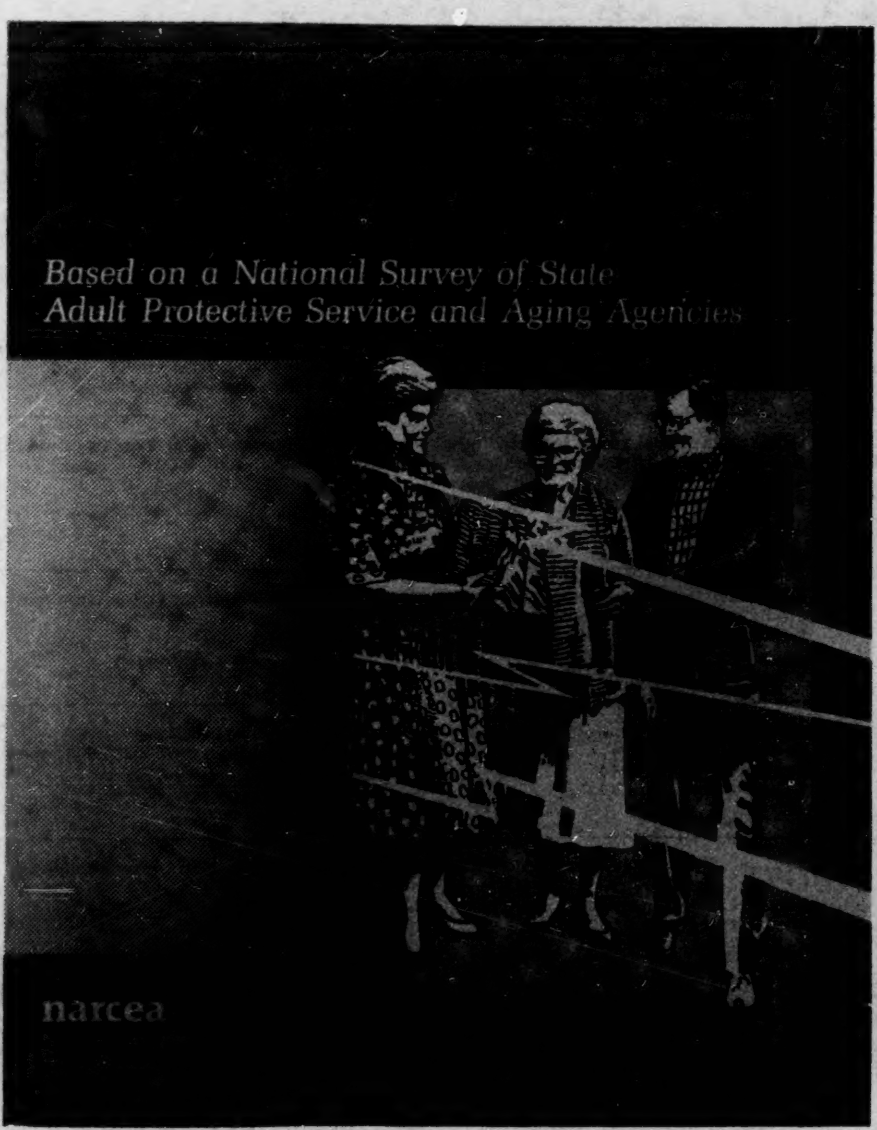
APPENDIX F

FY '89 CONTRACTED GUARDIANSHIP AGENCIES

Agency	Areas Covered
Family & Children's Service of Greater Lynn 111 North Common Street Lynn, MA 01902 Tel: (617) 598-5517	Chelsea/Revere/Winthrop, Greater Lynn, Merrimack Valley Mystic Valley, Minuteman, North Shore Comm. Mental Health, Senior Home Care/Gloucester
Family Services of Greater Boston 34 1/2 Beacon Street Boston, MA 02108 Tel: (617) 523-6400	Central Boston, Senior Home Care/ Boston III, Southwest Boston, Somerville/Cambridge, West Suburban, South shore
Jewish Family & Children Service 31 New Chardon Street Boston, MA 02114 Tel: (508) 227-6641	Central Boston, Senior Home Care/ Boston III, Southwest Boston, Somerville/Cambridge, West Suburban, Mystic Valley, Minuteman, Old Colony and Chelsea/Revere/Winthrop
Family Service Association of Greater Fall River 151 Rock Street Fall River, MA 02720 Tel: (508) 676-6811	Bristol, Cape Cod & The Islands, Old Colon Coastline and HESSCO
Northern Berkshire Mental Health 85 Main Street - Suite 500 North Adams, MA 01247 Tel: (413) 664-4541	Berkshire County & Franklin County
River Valley Counseling Center 326 Appleton Street Holyoke, MA 01040 Tel: (413) 536-8221	Greater Springfield, Highland Valley, Holyoke/Chicopee
Jewish Family Service of Worcester 646 Salisbury Street Worcester, MA 01609 Tel: (508) 755-3101	Baypath, Worcester, Montachusett, Tri-Valley

APPENDIX III

SUBMITTED BY DR. TATARA



Based on a National Survey of State
Adult Protective Service and Aging Agencies

narcea

SUMMARIES OF NATIONAL ELDER ABUSE DATA: AN EXPLORATORY STUDY OF STATE STATISTICS BASED ON A SURVEY OF STATE ADULT PROTECTIVE SERVICE AND AGING AGENCIES

Toshio Tatara, Ph.D., Director
National Aging Resource Center on Elder Abuse (NARCEA)
Washington, D.C. 20002
February 1990

This study was supported, in part, by a grant (No. 90-AM-0332) awarded to APWA by the Administration on Aging (AoA) to establish the National Aging Resource Center on Elder Abuse (NARCEA). Interpretations of the elder abuse statistics and other information provided by states are those of the author of this report (Toshio Tatara, Ph.D., director of NARCEA) and do not reflect the opinions or policies of the funding source or the organizations participating in the operation of NARCEA.

SUMMARIES OF NATIONAL ELDER ABUSE DATA

SUMMARY OF FINDINGS

- The national estimates for the counts of domestic elder abuse reports developed by the National Aging Resource Center on Elder Abuse (NARCEA) are as follows:

  FY 86 . . . . . . 117,000 reports
  FY 87 . . . . . . 128,000 reports
  FY 88 . . . . . . 140,000 reports

- From FY 86 to FY 88, there was a steady rise in the number of elder abuse reports, nationwide -- an increase of 19.7%. These reports include only those of elder abuse, neglect, and exploitation in domestic settings.

- While the true incidence of elder abuse is not known, it is believed that the reported cases represent only the tip of the iceberg. NARCEA estimates that, nationwide, there existed greater numbers of "reportable" domestic elder abuse incidents than those that were actually reported. These estimates of "reportable" incidents are:

  FY 86 . . . . . . 1.6 million
  FY 87 . . . . . . 1.8 million
  FY 88 . . . . . . 2.0 million

- In FY 88, the domestic elder abuse reporting rate among urban states (N = 33) was greater than that of rural states (N = 17), as follows:

Urban states	3.77 reports per 1,000 elders
Rural states	2.60 reports per 1,000 elders

- Information about specific types of domestic elder maltreatment that occurred in 24 states during FY 88 is available, as follows:

Physical abuse	26.3%
Sexual abuse	1.6%
Emotional abuse/neglect	11.0%
Neglect	37.2%
Financial/material exploitation	20.0%
All other types	2.8%
Unknown	1.1%

- Based on FY 88 data provided by 15 states, NARCEA identified the perpetrators of domestic elder abuse, as follows:

Adult children	30.0%
Grandchildren	1.9%
Spouse	14.8%
Sibling	1.7%
Other relatives	17.8%
Service provider	12.8%
Friend/neighbor	10.0%
All others	9.4%
Unknown	1.5%

- Available data show that older women are more likely to become victims of domestic elder abuse, as follows:

	FY 86	FY 87	FY 88
Ratio of female victims to male victims	1.65	1.63	1.79
Ratio of female elderly to male elderly in population	1.36	1.36	1.33
No. of states:	18	22	18

- The elder abuse substantiation rates were computed on the basis of data from 19 states, as follows:

	FY 86	FY 87	FY 88
Substantiation rate	54.2%	52.9%	53.8%

- Using FY 88 data, NARCEA calculated the elder abuse reporting rates for states with mandatory reporting systems and those with voluntary reporting systems, as follows:

	Mandatory System	Voluntary System
Reporting Rate	3.96	2.23
	(N = 43)	(N = 7)

* Number of reports per 1,000 elderly people (60 years of age and older).

ACKNOWLEDGEMENTS

The National Aging Resource Center on Elder Abuse (NARCEA) acknowledges, with appreciation, the receipt of assistance from state adult protective service (APS) and aging agencies in gathering statistical data on elder abuse that are summarized in this report. Staff of these agencies also were helpful in clarifying their initial responses and in providing additional information to NARCEA during the extended data analysis phase. Because the data that were gathered and analyzed by this study were extremely complex, without the cooperation of state personnel familiar with elder abuse data, this report would not have been completed.

NARCEA also would like to thank Ms. Carol Thornhill, the federal project officer at the Administration on Aging (AoA), for her advice and guidance throughout this study. Additionally, NARCEA is grateful to members of AoA's management team, which was formed for the purpose of overseeing the work of various national aging resource centers, for their review of the draft of this report. Finally, NARCEA extends its appreciation to Mr. Donald Fowles of AoA for his technical comments on the content of the report.

TABLE OF CONTENTS

Section Page

SUMMARY OF FINDINGS vii

ACKNOWLEDGEMENTS xi

I. INTRODUCTION AND THE PROBLEM OF ELDER ABUSE 1

The Problem of Elder Abuse 1

II. BACKGROUND AND DATA COLLECTION METHODOLOGY 2

Background 2

Data Collection Methodology 3

III. SUMMARIES OF KEY FINDINGS 7

- National Estimates for the Incidence of Domestic Elder Abuse Reports 9
- National Estimates for "Reportable" Domestic Elder Abuse Incidents 10
- Comparison of Domestic Elder Abuse Reporting Rates Between Urban and Rural States 11
- Types of Substantiated Domestic Elder Abuse Reports 12
- Trends in Types of Substantiated Domestic Elder Abuse Reports 14
- Characteristics of Elder Abuse Perpetrators 15
- Sex of Domestic Elder Abuse Victims 18
- Elder Abuse Substantiation Rates 19
- Counts of States that Operate "Mandatory" and "Voluntary" Elder Abuse Reporting Systems 20

- o Comparison of Domestic Elder Abuse Reporting Rates Between States With Mandatory Reporting Systems and those With Voluntary Reporting Systems 22

IV. PREVIOUS EFFORTS TO GENERATE NATIONAL ESTIMATE FOR THE INCIDENCE OF ELDER ABUSE REPORTS 23

V. CONCLUSIONS 27

APPENDICES

A. Technical Qualifications (TQ) 33

B. NARCEA Consortium Organizations, National Advising Committee Members, and NARCEA Staff 43

C. List of NARCEA Publications 47

I. INTRODUCTION AND THE PROBLEM OF ELDER ABUSE

The purpose of this report is to provide summaries of the elder abuse statistics for FY 86, FY 87, and FY 88 that the National Aging Resource Center on Elder Abuse (NARCEA) collected from state adult protective service (APS) and aging agencies. Although the report primarily is designed to serve the interests of state APS and aging professionals, other readers concerned with the problem of elder abuse also are expected to benefit from the information contained in this report.

The Problem of Elder Abuse

Studies and reports from professionals working in the fields of aging and adult protective services suggest that elder abuse is a widespread phenomenon, affecting hundreds and thousands of vulnerable elderly people across the country. However, because it is still largely hidden, elder abuse is difficult for policymakers to address effectively. Since the late 1970s, there have been increasing efforts to make an early identification of incidents of elder abuse, strengthen programs to serve victims and their families, broaden public awareness about the problem, and explore the causes of various types of elder maltreatment (including physical and sexual abuse, neglect, financial exploitation, self-neglect, and other forms of abuse or neglect). Today, most states operate mandatory or voluntary reporting systems that respond to reports of alleged elder abuse and neglect and administer treatment and prevention programs to meet the needs of victims and those who are at risk of being victimized. Professionals and experts in law enforcement, medicine, human services, and other disciplines participate in these programs. Yet, elder abuse still is not well understood by the general public and even by many professionals. Many programs continue to suffer from inadequacies and funding support from public and private sources remains insufficient.

The true incidence or prevalence of elder abuse is not known. As will be discussed later in this report, there have been several studies conducted in the past to generate national estimates for the prevalence of elder abuse. However, these studies surveyed a relatively small sample of the population, reviewed agency case records, or interviewed professionals working with elderly clients. None of these previous studies used data that were compiled by states' elder abuse reporting systems. The study summarized in this report represents the nation's first attempt to utilize such data for the purpose of generating national estimates for the incidence of elder abuse, as well as other estimates related to the nature and types of domestic elder abuse.

II. BACKGROUND AND DATA COLLECTION METHODOLOGY

Background

In the summer of 1988, the Elder Abuse Project of the American Public Welfare Association (APWA), in cooperation with the National Association of State Units on Aging (NASUA), conducted a survey of state APS and aging agencies to collect statistical data on elder abuse. The main objective of this survey was to draw a national picture of the extent of elder abuse problems, based on state statistics for reports of elder abuse, neglect, and exploitation. APWA and NASUA were particularly interested in developing national estimates for the incidence of elder abuse reports for FY 86, FY 87, and FY 88, but also hoped to cast light on several aspects of the elder abuse problem, using statistical data from states.

Subsequently, when an initial analysis of the data began in the early fall of 1988, APWA was awarded a cooperative agreement grant (No. 90-AM-0332) by the Administration on Aging (AoA) to establish a National Aging Resource Center on Elder Abuse (NARCEA). Therefore, the data analysis and report development related to this national survey were incorporated into the work plan of NARCEA.

Data Collection Methodology

Presented below is a brief summary of the data collection methodology and data analysis performed first by staff of APWA and then by staff of NARCEA:

Agencies That Were Surveyed

- The structured survey form, "Survey of States on the Incidence of Elder Abuse," was sent, in August 1988, by APWA to the state APS agencies in all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands (54 jurisdictions).

- The same survey form was sent by NASUA to the State Units on Aging (SUA) in all 54 jurisdictions, with a special request that SUAs cooperate with APS agencies, as appropriate, to respond to the survey. Each state was requested to prepare one completed survey form.

Response Rate

- A total of 48 jurisdictions (including the District of Columbia) returned their completed survey forms. In addition, NARCEA was able to obtain, by telephone, some data from two additional jurisdictions (Minnesota and Nebraska), bringing the total number of responding jurisdictions to 50 (or 92.6%). However, not all these 50 jurisdictions were able to provide their data on every data item in the survey.

- Guam, Puerto Rico, Pennsylvania, and the Virgin Islands (four jurisdictions) did not participate in the survey.

Types of Data Requested

- The survey form was divided into three sections, as follows:

  - Elder Abuse Reporting System -- this section was designed to collect information about the characteristics of state elder abuse reporting systems, as of September 1, 1988;

  - Elder Abuse Incidence Data -- this section was intended to gather statistical data on reports of elder maltreatment in domestic settings and the characteristics of these reports and "substantiated" cases (i.e., alleged elder abuse that was "confirmed" or "substantiated" as having taken place through an investigation); and

- Institutional Abuse of the Elderly -- this section was designed to obtain statistical data on reports and substantiated cases of institutional abuse.

Data Definitions

- AFWA and NASUA did not provide any standard definitions of elder abuse. Instead, states were asked to use their own definitions of elder abuse, neglect, and exploitation throughout the survey.

- However, for the purpose of understanding the nature of state data compiled by the survey, AFWA and NASUA included in the survey form a number of "data clarification questions." Responses to these clarification questions were later used to "interpret" the meaning of reported data, and, as needed, appropriate adjustments were made to some data. These adjustments were necessary for the purpose of achieving greater comparability of the reported statistics across all jurisdictions.

Overall Qualifications/Limitations Regarding the Survey Results

- On the whole, the survey has found that state data definitions and data gathering/reporting practices are more comparable than

APWA and NASUA initially thought -- particularly in the area of domestic elder abuse. Consequently, it was determined that state statistics for reports of elder abuse, neglect, and exploitation in domestic settings can be aggregated to generate national estimates.

o However, differences in data gathering/reporting practices exist among the responding states, although these differences do not appear to hinder efforts to generate national estimates for the incidence of elder abuse reports. Some of the major differences can be characterized as follows: (1) many states provided all reports of elder maltreatment received, while other states provided counts that excluded those reports which were "screened out" at intake; (2) while a number of states excluded reports of institutional abuse from their counts of domestic elder abuse, some states were unable to separate reports of institutional abuse from those of domestic abuse; and (3) a large number of states used "age 60" as the cut-off for counting elder abuse reports, but some states used "age 65" as the cut-off or were unable to disaggregate "counts of elder abuse" from "counts of adult abuse." Although appropriate adjustments to the reported data were made, when necessary, the effects of these differences in the state practices could not be totally erased.

- Despite its efforts in adjusting state data to present summaries of statistics for all data items, NARCEA was not successful in generating national estimates of certain data gathered by the survey. First, summaries of statistics for "ages of elder abuse victims" and "ages of those involved in self-neglect" are not included in this report because comparable data were available only from a few states. Second, data on institutional abuse are not presented because only a few states were able to provide "analyzable" data on institutional abuse. It was learned during the data analysis phase that some state aging agencies maintain statistics for institutional abuse. But NARCEA lacked the additional time and resources needed to collect and analyze these statistics.

III. SUMMARIES OF KEY FINDINGS

This report presents national summaries of the following elder abuse statistics analyzed by NARCEA:

- National estimates for the incidence of domestic elder abuse reports for FY 86, FY 87, and FY 88;

- National estimates for "reportable" domestic elder abuse incidents for FY 86, FY 87, and FY 88;

- Comparison of domestic elder abuse reporting rates between urban and rural states;
- Types of substantiated domestic elder abuse reports for FY 88 in 24 states;
- Trends in types of substantiated domestic elder abuse reports in 18 states;
- Characteristics of elder abuse perpetrators for FY 88 in 15 states;
- Sex of domestic elder abuse victims for FY 86, FY 87, and FY 88;
- Elder abuse substantiation rates for FY 86, FY 87, and FY 88 in 19 states;
- Counts of states that operate "mandatory" and "voluntary" elder abuse reporting systems; and
- Comparison of domestic elder abuse reporting rates between states with "mandatory" reporting systems and those with "voluntary" reporting systems.

National Estimates for the Incidence of Domestic Elder Abuse Reports

NARCEA's national estimates for the incidence of domestic elder abuse reports are as follows:

FY 86	117,000 reports
FY 87	128,000 reports
FY 88	140,000 reports

These estimates of reports pertain only to elder abuse, neglect, and exploitation in domestic settings and do not include counts of institutional abuse. It must be stressed that the above-mentioned counts of reports do not represent "unduplicated counts of reports" or "unduplicated counts of individuals." It is assumed that these counts are "duplicated," meaning that multiple reports made for one individual are included and also that some reports involved more than one victim. These types of duplication are intrinsic to any data generated by state reporting systems. Experts in the child abuse field have struggled with the problem of data duplication, without great success, in the past 15 years. Additional technical qualifications related to the above-mentioned national estimates are presented under Technical Qualifications (TQ)-1 in Appendix A.

National Estimates for "Reportable" Domestic Elder Abuse Incidents

Elder abuse is far less likely to be reported than child abuse, about which the public has gained greater awareness than it has about elder abuse. One recent study estimates that only 1 out of 14 elder abuse incidents actually comes to the attention of authorities.[1] Therefore, the reported elder abuse cases represent only the tip of the iceberg. Using this 14 to 1 ratio, NARCEA estimates that, nationwide, there existed greater numbers of "reportable" domestic elder abuse incidents than those that were actually reported to APS or aging agencies, and these estimates are as follows:

FY 86	1.6 million cases
FY 87	1.8 million cases
FY 88	2.0 million cases

The true incidence of elder abuse is not known. But given the nature of the problem, there is a high probability that only a small fraction of the "reportable" incidents of abuse, neglect, and exploitation of the elderly is actually reported to authorities each year. Elder abuse clearly is one of the most underrecognized, and therefore one of the most underreported, social problems in society today. Finally, the term, "reportable,", is used in this report to mean those elder abuse incidents that could be reported as "abuse allegations" to authorities according to the elder abuse definitions of a given jurisdiction.

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[1] Karl Pillemer and David Finkelhor (1988), "The Prevalence of Elder Abuse: A Random Sample Survey," The Gerontologist, 28: 51-57. NARCEA recognizes that the use of the 14 to 1 ratio may result in an over-estimate of the "reportable" elder abuse incidents in the country due to some differences in the definitions of elder abuse between the Pillemer/Finkelhor study and the NARCEA survey.

Comparison of Domestic Elder Abuse Reporting Rates Between Urban and Rural States

Using the FY 88 counts of domestic elder abuse reports, NARCEA estimates the domestic elder abuse reporting rates for urban and rural states,[2] as follows:

Urban states . . . . 3.77 reports per 1,000 elders
(N = 33)

Rural states . . . . 2.60 reports per 1,000 elders
(N = 17)

Further, five urban and five rural states both with the highest domestic elder abuse reporting rates in the respective categories for FY 88 are identified, as follows:

Urban

District of Columbia . . . . 9.54 reports per 1,000 elders

Washington . . . . 9.15 reports per 1,000 elders

Missouri . . . . 8.00 reports per 1,000 elders

Georgia . . . . 7.91 reports per 1,000 elders

Arizona . . . . 5.86 reports per 1,000 elders

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[2] The population data used to complete the elder abuse reporting rates were taken from: U.S. Bureau of the Census, "Provisional Estimates of the U.S. Population for Selected Age Groups, By State: July 1, 1988" in Current Population Reports, Series P-25 (Unpublished Data).

Rural

Idaho	9.05 reports per 1,000 elders
Kentucky	4.50 reports per 1,000 elders
Montana	4.24 reports per 1,000 elders
Maine	3.78 reports per 1,000 elders
South Carolina	3.76 reports per 1,000 elders

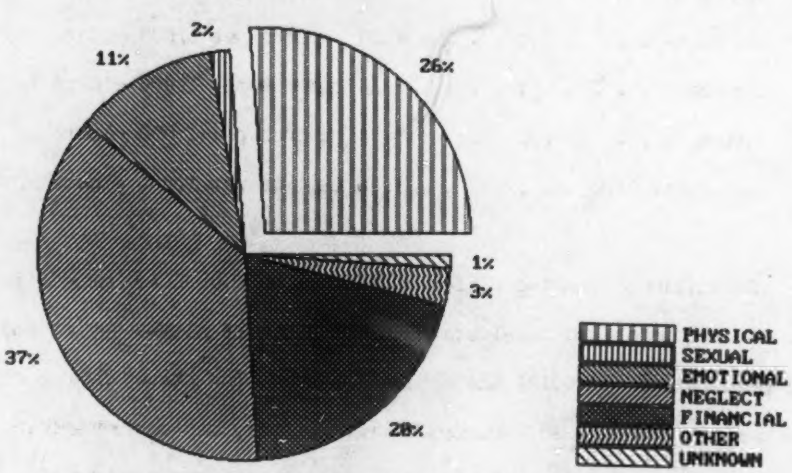
Definitions from two different sources were used to categorize states into urban and rural states. The State of Alaska (which had a reporting rate of 9.18) was defined as an "urban state" by one of the definitions but was included in the category of "other" according to the other definition. Technical qualifications related to the above findings are presented under TQ-2 in Appendix A.

Types of Substantiated Domestic Elder Abuse Reports

Findings on the incidence of specific types of domestic elder abuse reports, computed on counts of substantiated elder maltreatment provided by 24 states, for FY 88 are shown below in a frequency distribution table, as well as in a pie chart:

Physical abuse	26.3%
Sexual abuse	1.6%
Emotional abuse/neglect	11.0%
Neglect	37.2%
Financial/material exploitation	20.0%
All other types	2.8%
Unknown	1.1%

TYPES OF ELDER ABUSE REPORTS, FY88
SUBSTANTIATED REPORTS FROM 24 STATES



Self-abuse/neglect cases were not included in the abuse statistics. Further, NARCEA provided the above-mentioned abuse categories in the data collection instrument without descriptive definitions. States were asked to use their own definitions to supply data for each category. Although not fully verified, it appears that states categorized reports of elder maltreatment in accordance with their "major presenting problems" for reporting purposes. NARCEA recognizes that many reports can be included in more than one abuse category. Further, several other states also provided data on types of elder abuse, but their data could not be included in the analysis, mainly because these states used different categories of elder maltreatment. Technical qualifications and the names of the 24 states that were included in the above analysis are presented under TQ-3 in Appendix A.

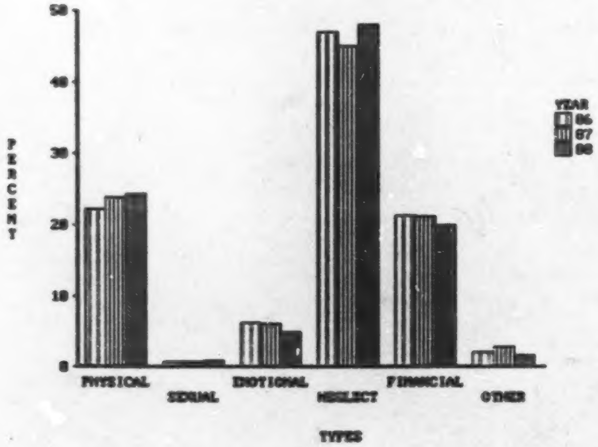
Trends in Types of Substantiated Domestic Elder Abuse Reports

NARCEA identified 18 states that provided statistics for different types of domestic elder abuse for FY 86, FY 87, and FY 88. Trends in the types of substantiated elder abuse reports in this three-year period are shown below in both a frequency distribution table and a bar chart:

	FY 86	FY 87	FY 88
Physical abuse	22.3%	23.9%	24.4%
Sexual abuse	0.8%	0.8%	0.9%
Emotional abuse/ neglect	6.3%	6.1%	4.9%
Neglect	47.0%	45.1%	48.1%
Financial exploitation	21.3%	21.2%	20.0%
Other types	2.1%	2.9%	1.7%

N=18

TYPES OF ELDER ABUSE REPORTS, FY86-FY88
SUBSTANTIATED REPORTS FROM 18 STATES



The patterns of distribution for elder abuse reports among the different categories of maltreatment did not change significantly during the three-year period. The names of the states that were included in this analysis are identified under TQ-4 in Appendix A.

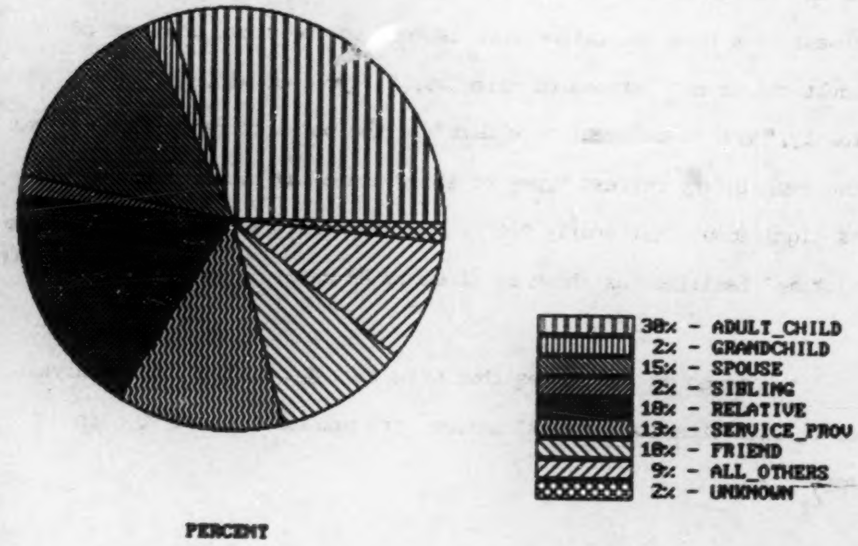
Characteristics of Elder Abuse Perpetrators

Based on statistics for FY 88 that were provided by 15 states, NARCEA identified the perpetrators of elder abuse. The information is presented below in a frequency distribution table, as well as in a pie chart:

Adult children	30.0%
Grandchildren	1.9%
Spouse	14.8%
Sibling	1.7%
Other relatives	17.8%
Service provider	12.8%
Friend/neighbor	10.0%
All others	9.4%
Unknown	1.5%

ELDER ABUSE PERPETRATORS

DATA FROM 15 STATES, FY 88



These FY 88 data provide an overall picture of those who are the perpetrators of elder abuse in domestic settings. At the same time, these data on perpetrators, along with the earlier-mentioned statistics for types of elder maltreatment, begin to shed some light on the dynamics of domestic elder abuse. NARCEA provided the above-mentioned categories of elder abuse perpetuators in the data collection instrument but did not give definitions of these categories. States used their own definitions of these categories to supply data for each category.

The research community has made some progress in identifying some of the causes of elder abuse in the past several years.[3] For example, researchers have identified such factors as "personal problems of adult children," "stress of caregiver," "cycle of violence in the family," and "impairment of elders" as the possible major factors that can explain why certain types of elder abuse may occur. Further, it is significant that nearly 70% of the perpetrators were members of the victims' families, as shown by these FY 88 data.

The names of the states that were included in the above analysis, along with technical qualifications, are presented under TQ-5 in Appendix A.

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[3] Some of the recent literature addressing the causes of elder abuse incude: G. J. Anetzberger, The Etiology of Elder Abuse by Adult Offspring (Springfield, Illinois: Charles C. Thomas, 1987); T. Fulmer and T. O'Malley, Inadequate Care of the Elderly: A Health Care Perspective on Abuse and Neglect (New York: Springer, 1987); Margaret F. Hudson, "Elder Mistreatment: Current Research" in Karl A. Pillemer and Rosalie S. Wolf (eds.) Elder Abuse: Conflict in the Family (Dover, Massachusetts: Auburn House Publishing Company, 1986): 125-150; J. Kosberg, "Preventing Elder Abuse: Identification of High Risk Factors Prior to Placement Decisions," The Gerontologist, Vol. 28 No.1, 1988: 43-50; L. R. Phillips, "Issues Involved in Identifying and Intervening in Elder Abuse" in Rachel Filinson and Stanley R. Ingman (eds.), Elder Abuse Practice and Policy (New York: Human Sciences Press, 1989): 86-93; J. Suitor and K. Pillemer, "Explaining Intergenerational Conflict When Adult Children and Elderly Parents Live Together," Journal of Marriage and Family, Vol. 50, No. 4 (November 1988): 1037-1047; and Rosalie S. Wolf, "Major Findings from Three Model Projects on Elder Abuse" in Elder Abuse: Conflict in the Family, 218-238.

Sex of Domestic Elder Abuse Victims

Using statistics for substantiated cases of elder abuse, NARCEA identified the sex of elder abuse victims for FY 86, FY 87, and FY 88, as follows:

	FY 86	FY 87	FY 88
Female victims	62.2%	62.0%	64.2%
Male victims	37.8%	38.0%	35.8%
No. of states:	18	22	18

These data clearly reveal that older women are more likely to become victims of elder abuse, neglect, and exploitation than older men. However, caution must be exercised in interpreting these statistics, because older women outnumber men in the elder population of this country. In order to determine whether older women are disproportionately victimized compared with older men in those states from which statistics were available, the average ratio of female elderly to male elderly (using "60 years of age" as the cut-off) for these states was calculated for each year and compared with the sex ratio for elder abuse victims. The comparison of these two ratios for FY 87 and FY 88 is shown in the following table:[4]

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[4] The population data used to calculate the sex ratios were taken from: U.S. Bureau of the Census, "Number of Females and Sex Ratio for Selected Age Groups, By State: 1988" in Current Population Reports, Series P-25 (Unpublished Data).

	FY 86	FY 87	FY 88
Ratio of female victims to male victims	1.65	1.63	1.79
Ratio of female elderly to male elderly in population	1.36	1.36	1.33
No. of states:	18	22	18

As shown above, it appears that older women are victimized slightly more often than older men in those states that were included in the analysis. The names of the states that were included in the above analysis are presented under TQ-6 in Appendix A.

Elder Abuse Substantiation Rates

The elder abuse substantiation rates (obtained from dividing the "number of substantiated cases" by the "number of reports") for FY 86, FY 87, and FY 88 were available from 19 states, as follows:

	FY 86	FY 87	FY 88
Substantiation rate	0.542 (or 54.2%)	0.529 (or 52.9%)	0.538 (or 53.8%)

It must be noted, however, that these percentages represent the "mean averages" of the rates provided by the 19 states. Attempts to use "raw counts" of reports were unsuccessful, because of "missing data" from a large number of states. Further, NARCEA attempted to use statistics that exclude self-neglect cases in computing these substantiation rates. However, it is not possible to determine whether NARCEA's attempts are totally successful because information about whether self-neglect cases were excluded from the count of substantiated cases was not available from some states. An informal review of statistics from several states indicates that, on the whole, when self-neglect cases are included in the count of substantiated cases, the substantiation rate rises to 75% - 80% in some states. It is clear that more studies are needed to understand both state practices on "substantiation of reports" and their data reporting practices related to "substantiated cases." Future research must generate separate statistics for "self-neglect cases" and "substantiated cases involving only victims of abuse by others." Until more information becomes available concerning how states treat self-abuse/neglect cases in the substantiation process, the substantiation rates presented in this report should be regarded as "tentative."

The names of the states that were included in the above analysis are presented under TQ-7 in Appendix A.

Counts of States That Operate "Mandatory" and "Voluntary" Elder Abuse Reporting Systems

As of August 1989, NARCEA's counts of jurisdictions operating "mandatory" and "voluntary" elder abuse reporting systems are as follows:

	Domestic Abuse	Institutional Abuse
Mandatory system	45	48
Voluntary system	8	4
No reporting system	1	2
No. of jurisdictions:	54	54

A total of 45 jurisdictions (including the District of Columbia, Guam, and the Virgin Islands) require, by law, that certain professionals (and the general public in some states) report suspected elder abuse in domestic settings to authorities (i.e., states with mandatory systems), while eight states maintain statutes that encourage everyone to voluntarily report domestic elder abuse (i.e., states with voluntary systems). The eight states that operate voluntary elder abuse reporting systems are: Colorado, Illinois, New Jersey, New York, North Dakota, Pennsylvania, South Dakota, and Wisconsin. Of these states, New Jersey is the only one that has not yet passed any state legislation pertaining to domestic elder abuse, but the reporting of alleged elder abuse is enforced through state administrative policy in most parts of the state. The Commonwealth of Puerto Rico does not operate an elder abuse reporting system.

For institutional abuse, a total of 48 jurisdictions (including the District of Columbia, Guam, and the Virgin Islands) maintain "mandatory" reporting systems, while only four states operate "voluntary" reporting systems. The four states that make the reporting of institutional abuse voluntary are: Colorado, North Dakota, Pennsylvania, and South Dakota. Two jurisdictions (Louisiana and Puerto Rico) do not operate any reporting systems related to institutional elder abuse.

Comparison of Domestic Elder Abuse Reporting Rates Between States With Mandatory Reporting Systems and Those With Voluntary Reporting Systems

Using FY 88 data, NARCEA computed the elder abuse reporting rates for states with mandatory reporting systems and those with voluntary reporting systems, as follows:

	Mandatory Systems	Voluntary Systems
Reporting rate	3.96* (N = 43)	2.23* (N = 7)

*Number of reports per 1,000 elderly people (60 years of age and older)

Several states that did not provide NARCEA with statistics were not included in the above analysis. In addition, the five jurisdictions with the highest reporting rates are identified from the "mandatory" and "voluntary" states, as follows:

Mandatory States		Voluntary States	
District of Columbia	9.54	Colorado	5.60
Alaska	9.18	New Jersey	2.83
Washington	9.15	Wisconsin	2.57
Idaho	9.05	New York	2.51
Missouri	8.00	North Dakota	2.39

*Number of reports per 1,000 elderly people (60 years of age and older)

Caution must be exercised in interpreting these findings because a number of factors, other than the type of reporting system itself, affect state reporting rates. Controlled studies that would focus on the possible factors influencing the elder abuse reporting rates are needed to clearly understand the specific impact of different types of reporting systems.

IV. PREVIOUS EFFORTS TO GENERATE NATIONAL ESTIMATES FOR THE INCIDENCE OF ELDER ABUSE REPORTS

In 1985, the American Public Welfare Association (APWA) and the National Association of State Units on Aging (NASUA) jointly conducted the nation's first survey of state APS and aging agencies to collect information about state policies and programmatic activities related to elder abuse. This survey, which was supported in part by funding from the Administration on Aging (AoA)[5], also collected state statistics for reports of elder abuse for FY 83, FY 84, and FY 85. Subsequently, APWA/NASUA included a summary of these statistics in their 1986 report, A Comprehensive Analysis of State Policy and Practice Related to Elder Abuse: A Focus on Legislation Appropriations, Incidence Data and Special Studies. However, because the elder abuse information systems of many states were not yet well-developed, the data on the incidence of elder abuse reports gathered through this survey were incomplete and did not permit APWA/NASUA to make any meaningful national estimates.

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[5] The original AoA grant (No. 90-AM-0155) was given to the University of Massachusetts Medical Center, which subcontracted with APWA to perform a study of states on elder abuse issues.

Using these incomplete state statistics for elder abuse reports, the director of the APWA/NASUA Elder Abuse Project conducted and published an exploratory study that developed estimates for the national incidence of reports of elder maltreatment.[6] Making various assumptions about state reporting practices for elder abuse and neglect data (for which information was scarce at that time), several sets of national estimates were generated by this exploratory study. One of these national estimates for elder abuse reports was based on an assumption that "states would include reports of self-abuse/neglect in the total number of reports of suspected elder abuse/neglect" and provided the following estimates:

Age	FY 83	FY 84	FY 85
60 years of age and older	107,000	125,000	130,000

The national estimates for reports of elder maltreatment for FY 86, FY 87, and FY 88 that were presented earlier in this report can be compared (albeit with some methodological differences) with the above-mentioned estimates, because state statistics upon which the estimates for FY 86, FY 87, and FY 88 are based also included "reports of self-abuse/neglect." In other words, these two sets of national estimates (i.e., one for FY 83, FY 84, and FY 85 and the other for FY 86, FY 87, and FY 88) were generated on the basis of the elder abuse definitions that are comparable with one another. Despite this overall compatibility in the elder abuse definitions between the two sets of national estimates, one word of caution must be mentioned: the estimates for FY 83, FY 84, and FY 85 were developed using data collected from less than 15 states, while the estimates for FY 86, FY 87, and FY 88 were derived from statistics gathered from 45 states (the FY 86 estimate), 46 states (the FY 87 estimate), and 43 states (the FY 88 estimate).

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[6] Toshio Tatara, "Toward the Development of Estimates of the National Incidence of Reports of Elder Abuse Based on Currently Available State Data: An Exploratory Study" in Rachel Filinson and Stately R. Ingman (eds.) Elder Abuse: Practice and Policy (New York: Human Sciences Press, 1989): 153-165.

In addition, academic researchers have conducted many studies of the prevalence of elder abuse, since the late 1970s.[7] Typically, these prevalence studies were designed to generate estimated counts or percentages of the elderly who were abused in a given population, but some researchers have developed "national prevalence rates" or "national estimated counts of elder abuse victims." The methodology used by these prevalence studies varied widely: some studies surveyed a sample of the population, while other studies reviewed agency case records or interviewed professionals working with the elderly. On the whole, most of these studies were "exploratory" in nature and were based on a relatively small sample of people or clinical records.

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[7] For example, see: M. R. Block and J. D. Sinnot, The Battered Elder Syndrome: An Exploratory Study (College Park, Maryland: University of Maryland Center on Aging, 1979); G. Gioglio and P. Blakemore, Elder Abuse in New Jersey: The Knowledge and Experience of Abuse Among Older New Jerseyans (Trenton, New Jersey: New Jersey Division on Aging, 1983); E. E. Lau and J. Kosberg (1979), "Abuse of the Elderly by Informal Care Providers," Aging, 299, 10-15; H. O'Malley, et al., Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals (Boston, Massachusetts: Legal Research and Services for the Elderly, 1979); and M. C. Sengstock and J. Liang, Identifying and Characterizing Elder Abuse (Detroit, Michigan: Wayne State University Institute of Gerontology, 1982).

However, the study conducted by Pillemer and Finkelhor in 1986 involved over 2,000 people in the survey sample and represented the "first large scale random sample survey of the problem." The study found that about 3.2% of the elder population studied had been victims of physical abuse, neglect, or chronic verbal aggression after reaching age 65. These researchers then translated these findings into national estimates of between 701,000 and 1,093,560 elder abuse victims.[8]

Because the objectives, methodologies, sources of data, and the meaning of findings are so different between incidence and prevalence studies,[9] the results of one type of study cannot be compared with those of another. However, both types of studies are important to policymakers and human service professionals and will contribute greatly to their increased understanding of elder abuse problems and their implications. At the present time, elder abuse incidence studies lag behind prevalence studies considerably in terms of quality and frequency. Various factors contribute to this situation, but the lack of reliable incidence data is a major one. Because incidence studies generally rely on statistical data on reports of elder abuse routinely gathered by public APS or aging agencies, the existence of effective APS/elder abuse information systems at these agencies is critically important. Further, national studies of the incidence of elder abuse cannot be conducted without "comparable" statistics generated by a large number of states.

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[8] Pillemer and Finkelhor (1988), "The Prevalence of Elder Abuse," 51-57.

[9] Incidence and prevalence are different and must not be confused. Generally, "incidence" refers to the occurence of a phenomenon during a specific time period. On the other hand, "prevalence" refers to the number of cases of a particular phenomenon that exists in a geographic area at a given time.

V. CONCLUSIONS

This report presented summaries of elder abuse statistics that NARCEA collected from state APS or aging agencies. Starting with the national incidence of elder abuse reports for FY 86, FY 87, and FY 88, various data summaries were presented. Because the elder abuse information systems of these agencies are incomplete and because elder abuse is grossly underreported across the country, the national estimates of elder abuse reports included in this report represent undercounts and other data summaries are "exploratory." Nonetheless, the estimates and summaries presented in this report will be useful in highlighting some important aspects of elder abuse problems for which information has been limited.

To assist states in further enhancing the capability of their elder abuse information systems, in the near future NARCEA will develop and distribute a publication, NARCEA's Suggested State Guidelines for Gathering and Reporting Domestic Elder Abuse Statistics for Compiling National Data. These guidelines will identify the "minimum essential" data sets that would be necessary for NARCEA to collect national statistics for domestic elder abuse.

Finally, Appendix A presents the technical qualifications (TQ) for some of the data summaries described in this report. These technical qualifications will provide readers with further insight into the great complexity of state elder abuse data. Appendix B lists the NARCEA consortium organizations, NARCEA's National Advisory Committee members, and the NARCEA staff. Finally, Appendix C displays the publications on elder abuse that are available from NARCEA.

APPENDICES

APPENDIX A

TECHNICAL QUALIFICATIONS (TQ) FOR DATA SUMMARIES PRESENTED

TECHNICAL QUALIFICATIONS (TQ)
FOR DATA SUMMARIES PRESENTED

TQ-1 — National Estimates for the Incidence of Domestic Elder Abuse Reports

The national estimates of the incidence of domestic elder abuse reports for FY 86, FY 87, and FY 88 presented in this report represent "estimates" for 50 jurisdictions for all three reporting periods. Because Guam, Puerto Rico, Pennsylvania, and the Virgin Islands did not provide NARCEA with any data, their estimates are not included.

Additionally, it is important to point out that the number of states that actually submitted incidence statistics to NARCEA varied from one year to another, as follows: 45 states for FY 86; 46 states for FY 87; and 43 states for FY 88. However, because the "missing states" for one reporting period provided counts of reports for another/other reporting periods, NARCEA was able to estimate the incidence of elder abuse reports for all "missing states," using the reported data for another/other periods. For example, the State of California was able to provide counts of elder abuse reports only for FY 88, but NARCEA generated estimated counts for FY 86 and FY 87 by applying the "national average rates of increase/decrease" to the FY 88 count of reports. The "national average rates of increase/decrease" among the three reporting periods were calculated separately on the basis of the statistics that actually had been provided by all participating states.

Further, the same method was used to calculate estimated counts for FY 88 for the District of Columbia, Florida, Georgia, and Minnesota, the states that had provided statistics for FY 86 and FY 87. Similar adjustments were made for other states, as well. In addition, NARCEA made other "adjustments" to the reported data of some states, as follows:

- While most states provided "counts of all reports received" (as requested), 13 states submitted "counts of reports after initial screening" and 3 states provided only "counts of substantiated reports." No adjustments were made to the "counts of reports after initial screening." However, NARCEA made appropriate adjustments to the data of the 3 states in order to generate estimates of "all reports received" for these states.

- A total of 29 states used "age 60" as the cut-off and provided only counts of elder abuse reports. However, 19 other states combined statistics for "adult abuse" and those for "elder abuse," and 2 other states used "age 65" as their age cut-off. Using the "estimated percentages" of elder abuse reports that were obtained, through follow-up telephone calls, from the 19 states, NARCEA generated estimates of counts of elder abuse reports for these states. No action was taken for the 2 states that had provided counts of abuse reports for the elderly 65 years of age and older.

- One state (Massachusetts) did not include statistics for self-abuse/neglect in the counts of elder abuse reports. No attempts were made to develop estimates of "all reports of elder abuse" for this state. NARCEA is aware that the elder abuse statutes of several other states do not address self-abuse/neglect, but it appears that all these states included in their statistics self-abuse/neglect cases, as well.

- Several states provided counts of reports for a period less than 12 months, but NARCEA "annualized" these counts to generate estimates for 12 months. Finally, 2 states (Illinois and North Dakota) provided data obtained only from "demonstration sites" within the state, and another state (New Jersey) submitted statistics that were collected only from a part of the state. Based on estimates supplied by a state official, NARCEA developed total estimated counts of elder abuse reports for New Jersey, but no adjustments were possible for statistics from the other two states.

As noted above, NARCEA made appropriate adjustments to the reported statistics of many states, whenever possible. However, given that not all necessary adjustments could be performed (not to mention the fact that elder abuse was grossly underreported), the national estimates of elder abuse reports for FY 86, FY 87, and FY 88 presented in this report are substantial undercounts of the incidence of such reports, nationwide.

TQ-2 — Comparison of Domestic Elder Abuse Reporting Rates Between Urban and Rural States

The Federal Reserve Bank of Kansas City defined a rural state as "a state where the ratio of non-metropolitan population to metropolitan population is greater than the average for all 50 states" and identified the following 17 jurisdictions as rural states:[1]

> Arkansas, Idaho, Iowa, Kansas, Kentucky, Maine, Mississippi, Montana, Nebraska, New Mexico, North Carolina, North Dakota, South Carolina, South Dakota, Vermont, West Virginia, and Wyoming.

Using this definition, the elder abuse reporting rate of these 17 rural states for FY 88 was calculated at 2.60 reports per 1,000 elders. Since the remaining 33 states were defined as urban states according to this definition, NARCEA computed the reporting rate of these states and found it to be 3.77 reports per 1,000 elderly people.

The U.S. Department of Agriculture (DoA) provided NARCEA with their definitions of a rural state, as follows:[2] a rural state is one in which "41 percent, or less, of the state's population residing in urban places within metro areas as defined in 1980." Based on this definition, DoA identified a total of 18 jurisdictions as rural states. The above-mentioned 17 states were all among the rural states, but New Hampshire was included as a rural state, according to the definitions of DoA. Further, Alaska was classified in the category of "other" by DoA.

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[1] Mark Drabenstot, et al., "The Rural Economic Policy Choice" Economic Review, Vol. 72, no. 1 (January 1987).

[2] Elliott J. Dubin, Geographic Distribution of Federal Funds in 1985 (Washington, D.C.: USDA Economic Research Service, 1989): 40.

TQ-3 — Types of Substantiated Domestic Elder Abuse Reports

NARCEA requested that states exclude reports of self-abuse/neglect from their counts of substantiated elder abuse reports. On the whole, most states followed this instruction. However, it was learned during follow-up telephone calls that many states usually include "substantiated self-abuse/neglect reports" in their statistics for "substantiated elder abuse reports." Despite these state practices, data on types of elder abuse from 24 states presented in this report are deemed to be comparable and exclude substantiated reports of self-abuse/neglect.

The 24 states included in the analysis are:

Alaska, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Michigan, Mississippi, Missouri, New Hampshire, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, West Virginia, and Wyoming.

TQ-4 — Trends in Types of Substantiated Domestic Elder Abuse Reports

The 18 states that were included in the analysis are:

Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Michigan, Missouri, New Hampshire, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Vermont, West Virginia, and Wyoming.

NARCEA determined that statistics provided by these 18 states are comparable in terms of data definitions and, therefore, lend themselves to straightforward aggregation.

TQ-5 — Characteristics of Elder Abuse Perpetrators

Technically, this data item is generally defined as "the relationship of abusers to victims" and attempts to find the identities of elder abuse perpetrators. NARCEA asked states to use only counts of "abuse by others" and exclude self-abuse/neglect reports. It appears that the 15 states included in the analysis all complied with these instructions. These 15 states are:

> Alaska, Illinois, Iowa, Kansas, Kentucky, Michigan, Missouri, New Hampshire, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Vermont, and Wyoming.

TQ-6 — Sex of Domestic Elder Abuse Victims

Self-abuse/neglect reports were not included in the statistics that were analyzed. The 18 states that provided their FY 86 data are:

> District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Michigan, Missouri, Montana, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, and Wyoming.

Further, 22 states submitted their statistics for FY 87, as follows:

District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Michigan, Missouri, Montana, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, West Virginia, and Wyoming.

Finally, the following 18 states were included in the analysis of the FY 88 data:

Alaska, Hawaii, Illinois, Iowa, Kentucky, Michigan, Missouri, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, West Virginia, and Wyoming.

TQ-7 — **Elder Abuse Substantiation Rates**

The 19 states that were included in the analysis are:

Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Missouri, New Mexico, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Vermont, and Wyoming.

APPENDIX B

NARCEA CONSORTIUM ORGANIZATIONS, NATIONAL ADVISORY COMMITTEE MEMBERS, AND NARCEA STAFF

NATIONAL AGING RESOURCE CENTER ON ELDER ABUSE (NARCEA)

Consortium Organizations

American Public Welfare Association (APWA)
810 First Street, N.E.
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Washington, D.C. 20002-4205

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2033 K Street, N.W.
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Project Coordinator

Joseph Flores, B.A. (APWA)
Secretary

In addition, **Margaret M. Rittman, M.A.** (APWA), **K. A. McCarthy** (APWA), and **Eileen M. Castle** (University of Delaware) contribute to the activities of NARCEA.

APPENDIX C

LIST OF NARCEA PUBLICATIONS

List of NARCEA Publications

- A Comprehensive Analysis of State Policy and Practice Related to Elder Abuse: A Focus on Legislation, Appropriations, Incidence Data and Special Studies - Report No. 1 (July 1986, 374 pp.) $28.00
- A Comprehensive Analysis of State Policy and Practice Related to Elder Abuse: A Focus on State Reporting Systems - Report No. 2 (September 1986, 101 pp.) $10.00
- A Comprehensive Analysis of State Policy and Practice Related to Elder Abuse: A Focus on Roles and Activities of State-Level Agencies, Interagency Cooperation Efforts, and Public Education/Information Campaigns - Report No. 3 (November 1986, 176 pp.) $10.00
- Adult Protective Services: Programs in State Social Service Agencies and State Units on Aging (April 1988, 276 pp.) $15.00
- Summary of Highlights of a National Conference on Elder Abuse: Strengthening Advocacy, Resources and Services, January 20 and 21, 1987 - (June 1987, 33 pp.) $10.00
- State Strategies for Assessing Risk in Elder Abuse Programs - (June 1987, 30 pp.) .... $ 6.00
- National Teleconference Call: A Practice Exchange Forum (June 1988, 27 pp.) .... $ 6.00
- "The Vexing Problem of Elder Abuse" Public Welfare (Spring 1988, 44 pp.) .... $ 7.00
- Highlights of a National Teleconference Series: Training and Technical Assistance Needs of State Elder Abuse and Adult Protective Service Programs (April 1989, 23 pp.) .... $ 6.00
- Summaries of National Elder Abuse Data: An Exploratory Study (February 1990, 47 pp.) .... $ 8.00
- American Indians and Elder Abuse: Exploring the Problem — A Report of Albuquerque Meeting (November 7-8, 1989) .... Forthcoming
- NARCEA's Suggested State Guidelines for Gathering and Reporting Domestic Elder Abuse Statistics for Compiling National Data ...... Forthcoming
- Elder Abuse: The Most Frequently Asked Questions and Answers — An Information Guide .... Forthcoming
- National Elder Abuse Research Agenda (tentative title) .. Forthcoming

For more information about these publications or elder abuse, please write or call NARCEA at: 810 First Street, N.E., Suite 500, Washington, D.C., 20002; (202) 682-2470 or (202) 682-0100.

APPENDIX IV

National Committee for the Prevention of Elder Abuse

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May 11, 1990

The Honorable Edward Roybal
Chairman
Subcommittee on Health and Long-Term Care
House Select Committee on Aging
U.S. House of Representatives
377 House Annex 2
Washington, DC 20515

Dear Chairman Roybal:

I would like to submit this written testimony on behalf of the National Committee for the Prevention of Elder Abuse to be included in the record of the recent May 1 hearing on elder abuse.

The National Committee is ready to work with the Subcommittee in the development of a national policy. Included in our membership are national, state, and local leaders in elder abuse research, education, training, administration, and practice. We would be pleased to provide information and consultation, to participate on study commissions and advisory committees, to prepare position papers, and to make ourselves available in any other way that would be helpful.

We congratulate the Subcommittee for its interest and support of this issue.

Sincerely,

Rosalie S. Wolf

Rosalie S. Wolf
President

RSW:ms
enclosure

University of Massachusetts Medical Center • 55 Lake Avenue North • Worcester, MA 01655 U.S.A.

WRITTEN STATEMENT OF ROSALIE S. WOLF, PRESIDENT
NATIONAL COMMITTEE FOR THE PREVENTION OF ELDER ABUSE

FOR THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

HEARING ON ELDER ABUSE
WASHINGTON, DC

MAY 1, 1990

WRITTEN STATEMENT OF ROSALIE S. WOLF, PRESIDENT NATIONAL COMMITTEE FOR THE PREVENTION OF ELDER ABUSE

The National Committee for the Prevention of Elder Abuse is a non-profit organization made up of individuals and groups who are concerned about the mistreatment of older and disabled persons. The purpose of the National Committee is to:

- Build the capacity of societal institutions to treat and prevent abuse and neglect of older and disabled persons;
- Conduct and support research on abuse and neglect;
- Educate the public about the victimization of elderly and disabled persons;
- Promote the dissemination of information among professionals and advocates;
- Develop educational and training programs for persons working with elderly and disabled persons; and
- Advocate for programs and policies that will meet the needs of victims, perpetrators, and their families; support the individual's right to self-determination; and prevent the mistreatment of older and disabled persons.

BACKGROUND

We acknowledge the pioneering efforts of the House Select Committee on Aging, firstly, in making the nation aware of the existence of elder abuse and secondly in proposing a series of policy alternatives to deal with the problem. The hearings and investigation undertaken by the Committee, which resulted in the publication of Elder Abuse (An Examination of a Hidden Problem) (U.S. House of Representatives, 1981), exposed in graphic detail the violence, exploitation, and neglect experienced by many older persons at the hands of family members or those in whom they placed their trust.

An update of the situation five years later in another Committee report Elder Abuse: A National Disgrace (U.S. House of Representatives, 1985) indicated that "elder abuse had not abated and perhaps was increasing" (2). Both in 1981 and 1985, the reports advocated for research into the causes, prevention, treatment and national incidence; assistance to the states for reporting, investigation, assessment and treatment; and changes in Title XVIII, XIX, and XX that would encourage families to care for elderly relatives. Despite these efforts and the continued dedication of some legislators to the issue, no overall federal policy has been enacted.

The major source of funds for elder abuse activities is the Title XX Social Services Block Grant (SSBG). Through the years there has been a gradual erosion of the buying power, if not actual SSBG dollars, available to the states for protective services. In fiscal year 1985, 46 states used the SSBG to support adult protective and emergency services; by 1987, the number had dropped to 40. Some of the shortfall has been covered by state funds, but most states have found themselves in the untenable position of having to make choices between meeting increased needs for abused children or funding adult protective services. While there are other block grants that could be used to serve abused and neglected elders, such as the Alcohol, Drug Abuse, and Mental Health Services Block Grant and the Preventive Health and Health Services Block Grant, competition to support existing programs leaves little for the development of new services or constituencies.

Although several attempts have been made to address elder abuse in other legislation, the results have been discouraging. The Child Abuse Prevention and Treatment Act Amendments of 1984 authorized demonstration grants to establish programs for the prevention of family violence, including shelters and related assistance for victims, among whom were listed older adults. Because most of the state agencies chose to use the small amount of money to maintain their domestic violence shelters, which are not suitable for most older victims, very little, if any, of the funds have been expended to assist the elderly. A reauthorization of that legislation in 1988 again named the elderly as eligible for service through shelters, but, without special concessions to the needs of older persons, there is little expectation that these funds will be used for that purpose. Funding for training police about elder abuse was also authorized in the latest version of the Act. Improving the police's ability to respond to elder abuse is important in the development of prevention and treatment activities at the local level, but it only serves one component of a required comprehensive approach.

The Older Americans Act as a source of funds for treatment and prevention of elder abuse has also been a disappointment. In adding part G to Title III in the 1987 amendments, which authorized payment to the states to carry out a variety of prevention and investigation activities, the late Claude Pepper tried a new tactic to get Congress to respond. Unfortunately, because of the budget reduction bill that year, the appropriation was not authorized, although part G remains. So far, it is not known how much of the Title III monies are being used for elder abuse prevention and treatment activities, but with increasing demand for the traditional services, it is a very small amount, if any.

Through Title IV (Training, Research, and Demonstration Projects and Programs) the Administration on Aging in the past decade has supported several exploratory studies, conferences, model projects, information dissemination programs, state public awareness campaigns, and most recently, a National Aging Resource Center on Elder Abuse. Although these activities reflect an ongoing interest at the federal level, the response and the dollars allotted in proportion to the nature and scope of the problem are minimal at best. When compared to the role of the U.S. Children's Bureau and the National Center for Child Abuse and Neglect in promoting the cause of child abuse treatment and prevention, the record of accomplishment pales in comparison.

It is cur contention that while the states and local communities should have major responsibility for the delivery of services to prevent and treat elder abuse, the federal government must play a leadership role in policy direction and the promotion of research, demonstration, and training. We now realize after a decade of activity that adding elder abuse to existing legislation has not been a successful strategy. Including elder abuse within long term care legislation might also have the same outcome unless accompanied by specific appropriations. A national policy is needed, if significant gains are to be made in assuring all older persons of a life free from violence wherever they live.

RECOMMENDATIONS

We urge the establishment of a National Center on Elder Abuse Prevention

a. to be under the jurisdiction of the Secretary of Health and Human Services, but not within the Administration on Aging;

We believe that establishing the program within the Administration on Aging ignores the reality (1) that in three fourths of the states, adult protective services based in departments of social services are the lead agencies for elder abuse (NASUA/APWA, 1988) with responsibility for both abused and neglected disabled persons 18 years and older, as well as the elderly: (2) that in most cases of elder abuse a family systems approach may be the most appropriate intervention, with recognition that the needs of both the victim and perpetrator must be addressed; and (3) that the medical, psychological, social, legal, and ethical issues embodied in abuse cases require collaborative working relationships among aging groups, adult protective services, mental health program, and other human service systems.

b. to carry out the following activities:

(1) conduct national surveys on the extent and nature of elder abuse and neglect;

So that accurate estimations of the scope of the problem can be made, we need as soon as possible a national prevalence study of elder abuse with plans to conduct a follow-up survey five or ten years later, as has been done with child and spouse abuse (Straus, M.A. & Gelles, R.A. (1986). Canada has just completed a national random sample telephone survey of 2000 Canadian elderly living in private dwellings which found that about 40 persons per 1,000 were victims of one or more forms of maltreatment (physical abuse, verbal aggression, material abuse, and neglect) (Podnieks et al., 1990). Material abuse was the most prevalent type, present in 25 cases per 1000.

So far, only one prevalence study has been carried out in the United States, and it was confined to the metropolitan Boston area. It revealed that 32 per 1000 individuals 65 year and older suffer from physical abuse, verbal aggression and/or neglect, which could represent, if a national survey yielded similar findings, from 701,000 to 1,093,500 victims (Pillemer & Finkelhor, 1988). With material abuse included, the numbers could go almost as high as 1 million to 1.3 million.

Not only do we have to have better data on prevalence, but we also need more accurate statistics on the characteristics of victims and perpetrators. The community surveys above have revealed that roughly equal numbers of men and women are victims and that spouse abuse is more common than abuse by adult children. These findings are clearly different from those reported by agencies.

Although the focus of efforts in elder abuse has been on those situations that occur in domestic settings and involve family members, there is enough evidence to show that elder abuse and neglect are present in institutional or group settings. To date, the reports have been anecdotal. A systematic study of this form of mistreatment is sorely needed.

(2) identify valid risk factors and prognostic measures;

Prevention depends on the identification of risk factors and a better understanding of why and how the problem occurs. The state-of-the-art in elder abuse investigation now requires more scientifically rigorous (and expensive) research than was carried out in the past. The small, exploratory studies which helped to characterize the problem are no longer adequate for explaining the phenomenon or designing treatment and preventive programs. A commitment by the federal government to support basic research of the problem is critical.

(3) assess the effectiveness of various preventive and treatment strategies;

Given the number of personnel involved in responding to cases of elder abuse nationwide, not only in the adult protective services, but in health, mental health, law enforcement, criminal justice, and aging, it is surprising that so little attention has been given to program evaluation. The cases are known to be among the most complex and difficult facing the human service system. Not only traditional case work and case management must be reviewed, but also newer trends in intervention, which involve the police and prosecuting attorneys, should be subject to examination. Multi-state studies can only be carried out with federal support.

(4) evaluate the states' mandatory reporting practices;

One of the most controversial aspects of adult protective services is mandatory reporting. It is interesting to note that the last three states to adopt elder abuse legislation, after carefully reviewing the pros and cons, decided against including it (North Dakota, Illinois, Pennsylvania). Advocates of mandatory reporting believe that many cases would not become known to the adult protective system unless professional personnel were required to report. Opponents say that mandatory reporting is based on the faulty assumption that all elders are incompetent and unable to report themselves. Such inferences, they feel, infantalize the elder's position in society, foster negative stereotypes of the aged, and limit older persons' ability to control their own lives (Faulkner, 1982; Crystal, 1986; and Lee, 1986).

Rather than pass legislation that requires mandatory reporting of all states, we recommend that the decision be left to the states. In addition, we urge support of studies that will evaluate the merit of the legislation.

(5) operate as a national clearinghouse for information and best practices;

The rapid enactment of elder abuse legislation and implementation of programs at the state and local level have produced new and promising data sources, intervention techniques, training programs, and service delivery models. A central place for the collection and dissemination of this information is vital in the continuing development of an adequate national response to elder abuse. The National Aging Resource Center on Elder Abuse is the beginning of such an effort, but is limited by the available funds and its position as a discretionary program under AOA jurisdiction. A broader mandate is required to provide the requisite service and national presence commensurate with the scope of the problem.

(6) provide multidisciplinary training and consultation;

The complexity of issues involved in elder abuse cases, often health, social, legal, ethical and/or financial, requires that practitioners not only be exceptionally well informed and trained, but that they be prepared to work as part of multidisciplinary teams and task forces. One of the most significant achievements of the elder abuse movement is the creation of community based inter-organizational structures for problem solving and policy development. A National Center can make a significant contribution to the field by providing training models and consultation which focus on multidisciplinary approaches to treatment and prevention.

(7) develop and maintain a national data reporting system;

Although every state now has a system for receiving reports on elder abuse, the variation in criteria and in definitions hinders the effort to obtain national incidence data. The report issued by the National Aging Resource Center on Elder Abuse (1990) reflects the difficulty in trying to estimate the problem with incomplete data and diverse methodologies. Assistance will be needed by the states in adoption and utilization of a minimum data set that can be aggregated for calculating annual national incidence figures.

(8) and disseminate grants to states and organizations to demonstrate effective programs in prevention and treatment.

> A broad array of service programs have been listed as ideal components of an elder abuse service system, including emergency shelter, respite care, MD home visits, foster care, alcohol counseling, telephone assurance, homemaker services, caregiver training, victim support groups, civil commitment procedures, police coordination, public awareness campaigns, and others. Much remains to be done, however, in shaping these programs to best fit the needs of older victims and their families. Demonstration grants must be available to assist the state and local communities in establishing effective response systems for elder abuse.

More than ten years ago, the Congress opened the eyes and ears of the nation to the pain and suffering endured by thousands of older persons mistreated by family members or those in whom they had placed their trust. The leadership role, which Congress played in that phase of activity, is needed in the years ahead to bring about significant gains in understanding the nature of the problem and in providing the solutions. We strongly urge the establishment of a National Center for Elder Abuse Prevention to serve as a focal point for information, training, research, and demonstration.

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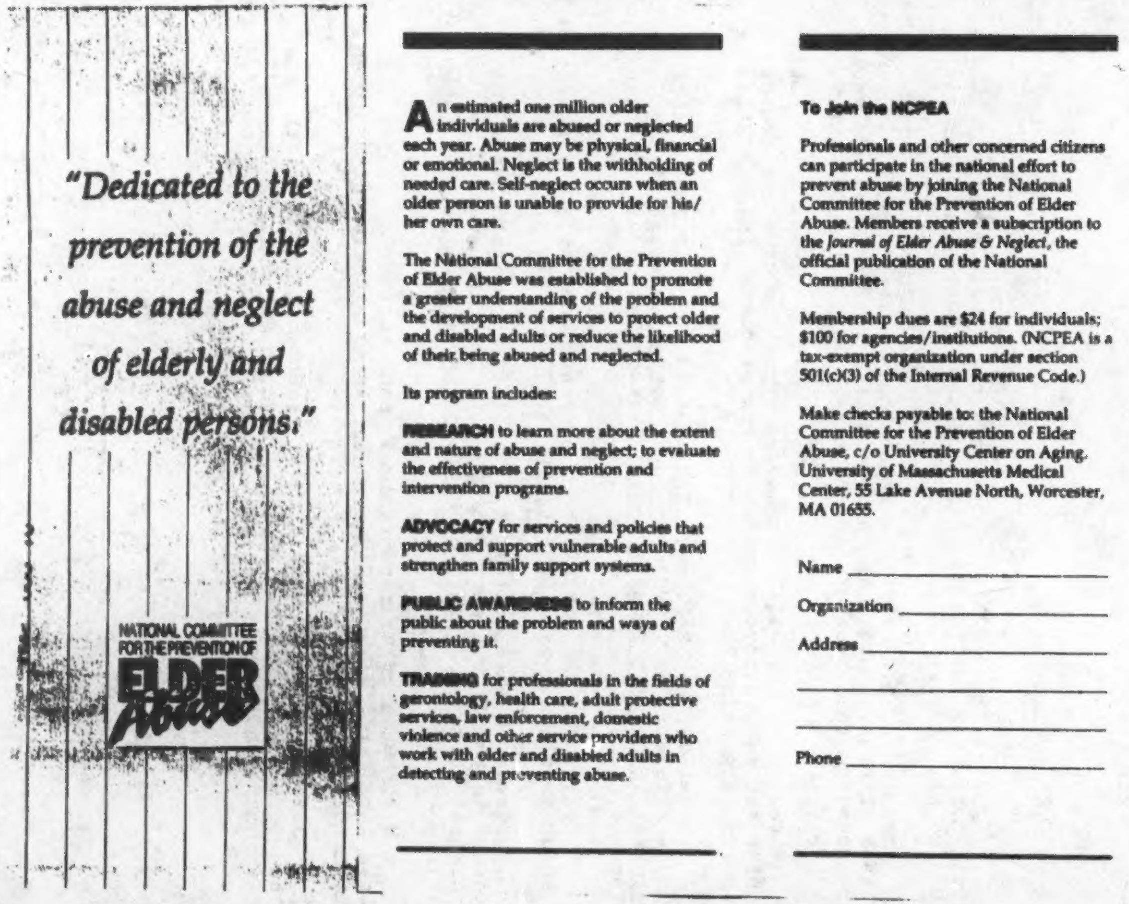

"Dedicated to the prevention of the abuse and neglect of elderly and disabled persons."

NATIONAL COMMITTEE FOR THE PREVENTION OF ELDER Abuse

An estimated one million older individuals are abused or neglected each year. Abuse may be physical, financial or emotional. Neglect is the withholding of needed care. Self-neglect occurs when an older person is unable to provide for his/her own care.

The National Committee for the Prevention of Elder Abuse was established to promote a greater understanding of the problem and the development of services to protect older and disabled adults or reduce the likelihood of their being abused and neglected.

Its program includes:

RESEARCH to learn more about the extent and nature of abuse and neglect; to evaluate the effectiveness of prevention and intervention programs.

ADVOCACY for services and policies that protect and support vulnerable adults and strengthen family support systems.

PUBLIC AWARENESS to inform the public about the problem and ways of preventing it.

TRAINING for professionals in the fields of gerontology, health care, adult protective services, law enforcement, domestic violence and other service providers who work with older and disabled adults in detecting and preventing abuse.

To Join the NCPEA

Professionals and other concerned citizens can participate in the national effort to prevent abuse by joining the National Committee for the Prevention of Elder Abuse. Members receive a subscription to the *Journal of Elder Abuse & Neglect*, the official publication of the National Committee.

Membership dues are $24 for individuals; $100 for agencies/institutions. (NCPEA is a tax-exempt organization under section 501(c)(3) of the Internal Revenue Code.)

Make checks payable to: the National Committee for the Prevention of Elder Abuse, c/o University Center on Aging, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655.

Name ______________________

Organization ________________

Address ____________________

____

____

Phone ______________________

City of Chicago
Richard M. Daley, Mayor

Department on Aging
and Disability

Donald R. Smith
Commissioner

510 North Peshtigo Court
Chicago, Illinois 60611
(312) 744-4016 (Voice)
(312) 744-6777 (TDD)

May 14, 1990

Representative Edward Roybal, Chairman
U.S. House Select Committee on Aging
A 712 - House Office Building - Annex 1
Washington, D.C. 20515-3661

Dear Representative Roybal:

Enclosed is a statement prepared to communicate the City of Chicago Department on Aging and Disability's experience with Elder Abuse clients. We want to share the benefit of our experience with you for the official record of your committee.

Sincerely,

Donald R. Smith
Commissioner

DRS:JL:sr

Enclosure

City of Chicago
Richard M. Daley, Mayor

Department on Aging and Disability
Donald R. Smith
Commissioner

510 North Peshtigo Court
Chicago, Illinois 60611
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Statement on Elder Abuse Submitted to the Select Committee on Aging, U.S. House of Representatives

Donald R. Smith
Commissioner
Chicago Department on Aging
and Disability
May 14, 1990

The City of Chicago Department on Aging and Disability (DAD), Chicago's Area Agency on Aging and its municipal department with responsibility for service delivery to older individuals and persons with disabilities is pleased to submit a statement on the problem of elder abuse to the Select Committee on Aging, U.S. House of Representatives.

During calendar year 1989 Protective Services staff from my Department investigated 555 reports of elder abuse occurring in the general community. Cases are referred to my department via a toll free abuse hotline, our information and referral system, other service providers, apartment managers and friends and relatives of the abused. Among the types of abuse reported most often are complaints involving physical, financial and emotional abuse, which in some instances are perpetrated by relatives or caregivers. After cases have been identified Protective Services staff visit the home to determine the most appropriate strategies for helping the person. In some situations where staff must travel to dangerous domestic situations, officers from the Chicago Police Department accompany our staff.

It is clear that trends indicate increasing prevalence of elder abuse in Chicago. To illustrate this point, during the six month period from October 1, 1989 to March 31, 1990 there were an additional 27 cases of abuse reported over the same time period last year. The Department on Aging and Disability has recently joined forces with the Illinois Department on Aging to increase our efforts to combat the elder abuse problem.

Abuse cases are found throughout the City of Chicago. I want to inform the Committee about the kind of clients often seen by my Department's Protective Services staff. I believe these situations are typical of those found by units located in other urban areas.

Client A

Church members finally gained access to the home of an ill homebound woman and found her incapacitated on the couch and begging for help. They called the DAD Protective Services unit who arranged for a Chicago Police Department escort, since the alcoholic son and his girlfriend were very hostile. The couple took over the mother's home when she became a widow. The elderly woman (73 years old) was too weak to walk, had no personal hygiene care, was malnourished and dehydrated, and had no medications for her hypertension. The son took her check and cashed it for alcohol. The Police Department called the paramedics and the DAD Elder Abuse staff accompanied the elderly woman to the hospital and arranged for her admission due to her dangerously high blood pressure level. The elderly woman stated she would never go back to her home and requested nursing home placement. The Church members regularly visit her and, health permitting, bring the elderly woman to Church services.

Client B

The woman neighbor had not seen another neighbor, an elderly man (78), for several months and was concerned. A stranger, a man (42) had moved into the elderly man's apartment and put iron bars and padlocks across the apartment door. The doors were kept locked while he was gone all day. Elder Abuse program staff made a home visit, accompanied by the Chicago Police Department Senior and Disabled Senior Services unit. The Chicago Fire Department had to cut through the iron bars because the elderly man was unable to unlock the door. The elderly man was confused, malnourished, dehydrated, and could barely walk. DAD Protective Services staff arranged for transportation to a hospital medical center and relocated the client to a nursing home for needed nursing care.

Client C

The client is a 72 year old female, diagnosed with Alzheimer's Disease. Client C is living in her own home with other family members, which includes her 49 year old son, 26 year old granddaughter and her 2 children.

The 49 year old son is the abuser and admitted to using physical means (i.e. rough handling) to prevent his mother from leaving the house. The client has a tendency to wander outside, if not supervised. This activity takes place generally in the late evening and nights, when her son is home from work and trying to rest.

The family was counseled about the wandering patterns and were given suggestions to help with dealing with Alzheimer's patients. The family agreed to place the client in adult day care so the individual could remain in her own home for as long as possible. Follow-up services are being provided through our Case Management System.

Client D

Client D is a 65 year old male, who lives alone in subsidized housing. The client has several medical problems, making it difficult to care for himself. The client had a stroke about one year ago, is diabetic, uses a cane to ambulate, and has a speech impediment. The person requires a special diet and daily medication.

The client's family consists of 2 daughters (age 25 and 26) and a son 30 years old. The client stated his 2 daughters take money from him when they come to visit. Sometimes money is given to daughters to shop for food, but they never return with food or change.

However, the individual's major concern was physical abuse from his 30 year old son. The client's son would push and shove him around, if the client refused to give him money. The abuser would come to the client's apartment at the beginning of each month demanding money. When the client refused to hand over his money, the abuser would yell, push and shove the client. There was one occasion when the client was pushed out into the hallway and pinned against the wall for not giving the abuser money.

The client's neighbors and building janitor have called the police (911) several times to report physical abuse, but the abuser left before the police arrived. The client has refused to file any charges against his son. The client only wanted to be relocated and not have his family know his location.

The client was assisted with medical treatment and was placed in a sheltered care facility, where he is safe and the financial exploitation and physical abuse does not occur.

As you can see, the variety of problems which comes to the attention of my staff are incredibly diverse. It is a constant challenge to provide adequate service to these individuals, especially those complicated cases which drain limited community resources.

I urge the Select Committee on Aging to use its significant leverage in exploring how adequate resources can be developed for communities wishing to tackle these serious problems. Abused persons will get proper attention only when the federal government makes a commitment for expanded community education about elder abuse as well as increasing federal dollars for services to this vulnerable population.

Thank you for this opportunity to comment.

AARP

May 15, 1990

The Honorable Edward R. Roybal
Chairman
Select Committee on Aging
Subcommittee on Health and Long Term Care
U.S. House of Representatives
377 Annex II
Washington D.C. 20515

Dear Chairman Roybal:

The American Association of Retired Persons is pleased to submit testimony for the record in conjunction with the Subcommittee's recent hearing entitled, "Elder Abuse: A Decade of Shame." Enclosed please find AARP's statement. If you or your staff should have any questions or wish to discuss this matter further, please call Larry White (728-4830) in our Federal Affairs Department.

Sincerely,

John Rother

John Rother
Division Director
Legislation, Research, and Public Policy

American Association of Retired Persons 1909 K Street, N.W. Washington, D.C. 20049 (202) 872-4700
Louise D. Crooks *President* Horace B. Deets *Executive Director*

AARP

STATEMENT

for the record

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

ELDER ABUSE

submitted to the

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

of the

SELECT COMMITTEE ON AGING

U.S. HOUSE OF REPRESENTATIVES

May 15, 1990

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
Louise D. Crooks *President* Horace B. Deets *Executive Director*

The American Association of Retired Persons (AARP) appreciates this opportunity to address the important issue of elder abuse. The Association has been concerned about this problem since reports of mistreatment or abuse of older persons first appeared in the late 1970s. At that time, elder abuse was generally perceived as an isolated and localized problem involving a few frail elderly. The Association is heartened by the Committee's continued interest in this issue and its role in bringing what was a hidden and vaguely defined problem into the light. At the same time we are distressed by recent news reports that over the past ten years, the incidence of elder abuse has increased rather than decreased.

There is continued evidence that the abuse of older persons continues to be prevalent in America. In 1989, AARP commissioned a national survey which included questions on elder abuse. In a random sample of 17,528 persons age 45 and over, 81 percent of the respondents stated that they believe elder abuse occurs. While 42 percent believed that it occurs a lot, 39 percent stated that it occurs some, and some 15 percent knew first hand of abuse cases.

Although the States have made inroads into the problem, it is clear that they cannot successfully combat elder abuse alone. AARP urges Congress to enact legislation to create a National Elder Abuse Center to assist the States and local agencies in combating this deplorable behavior. Such a Center would help the States to identify, treat and prevent the increasing incidence of elder abuse. Moreover, it would assist the States to overcome several deficiencies that impede progress in eliminating abuse of elders: the lack of standardized definitions and classification of elder abuse, accurate documentation of elder abuse, and appropriate and adequate intervention services. Our comments focus on these issues and the lack of funds for elder abuse services.

Definitions and Classification of Elder Abuse

The lack of common definitions and accurate documentation of elder abuse is a serious problem. Localized and informal language has guided data collection and classification, resulting in a plethora of definitions of elder abuse that are not uniform across the states. Because inconsistent definitions prevent the comparison and integration of studies, there exists no reliable and valid documentation of elder abuse. Many experts believe that the actual elder abuse rate is much higher than present estimates that are based on piecemeal data. Poor documentation results in inadequate funding for services. Federal legislation should require that a national Center assist the States in establishing standardized definitions and classification of elder abuse that are uniform across the states. The legislation should require the Center to compile, publish and disseminate accurate incidence and prevalence data at the national and State levels.

Appropriate and Adequate Intervention

Elder abuse is a complex and multifaceted phenomenon that defies any one intervention. Many local agencies and organizations have developed successful strategies to address aspects of the problem, however. For example, AARP provides training to older persons and service providers throughout the country with the aim of preventing abuse before it occurs. The Federal government should fund new research and demonstration projects and require existing information to be collected and disseminated to provide the States with effective and appropriate guidelines and models of elder abuse intervention.

Insufficient Funds for Services

The primary source of Federal funds that the States use for elder abuse services is the Title XX Social Services Block Grant (SSBG). Since 1980 this Federal commitment has been cut nearly one-third through the combined effect of spending reductions and inflation. A survey of the States and the District Columbia revealed that fewer than half, or 47 percent, of the States use SSBG funds for adult protective services. Thus, while states have enacted statutes requiring reporting of elder abuse and the provision of services, they have neither funded the specific activities mandated nor provided for the financing of ancillary services needed in connection with the investigation of reported abuse. The Federal government should increase SSBG funds provided for this purpose.

In conclusion, the Association applauds the Committee's efforts to combat elder abuse. Further progress requires adequate funding and legislation to assist the States in defining, identifying, correcting, and preventing abusive situations while protecting the rights of the vulnerable victim.

EDDY S. TANAKA
DIRECTOR

MAY 3 [illegible]

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC SOCIAL SERVICES
3401 RIO HONDO AVENUE, EL MONTE, CALIFORNIA 91731/TEL: (818) 572-6720
P.O. BOX 5493, EL MONTE, CALIFORNIA 91731

May 21, 1990

MAY 29 1990

Honorable Edward Roybal
United States House of Representatives
Washington, D.C. 20515-0525

Dear Representative Roybal:

At your request we are enclosing written remarks for the May 1 hearing of the House Select Committee on Aging.

We appreciate your continued efforts on behalf of abused and neglected elders. I hope that you will finalize plans to schedule a field hearing on elder abuse and HR 220, The Prevention, Identification and Treatment of Elder Abuse Act, in Los Angeles in August. This would provide you with an unique opportunity to see how Adult Protective Services programs operate in Los Angeles County and review local issues and concerns. We would also be happy to arrange for you to visit a Department of Public Social Services Adult Protective Services office during your visit.

I look forward to hearing from you at your earliest convenience. Your staff can reach me at (818) 572-5502.

Sincerely,

Ray Garcia, Director
Bureau of Program Planning and
Development

RG:GS:mo

Enclosure

REMARKS BY RAY GARCIA

DIRECTOR, BUREAU OF PROGRAM PLANNING AND DEVELOPMENT
LOS ANGELES COUNTY
DEPARTMENT OF PUBLIC SOCIAL SERVICES

CHAIRMAN ROYBAL AND MEMBERS OF THE COMMITTEE:

I appreciate this opportunity to share with you our views on the compelling problem of adult abuse and neglect.

As you are aware, in recent years, the problem of family violence has emerged as a serious and perplexing societal concern. We were outraged at the scope and severity of child and spousal abuse. As these problems emerged, society responded in a deliberate and comprehensive manner. The media focus on family violence served to heighten public awareness of the problem. Government responded with new programs directed toward protection, prevention and rehabilitative services.

Now, as we are beginning to address the issues of child and spousal abuse, the problem of adult abuse is evolving as a new aspect of familial violence. Adult abuse and neglect is a multi-dimensional problem which affects the lives of many adults. It involves a variety of harmful situations affecting persons over 65 or adults between 18 and 64 who are unable to protect their own interests because of physical or mental limitations. These situations include:

- Physical abuse where victims are beaten, bruised or physically harmed.
- Mental/emotional abuse when adults are deliberately subjected to fear, confusion, severe depression or emotional stress by threats, harassment, or other forms of intimidation.
- Neglect when elders or dependent adults are subjected to levels of care that are less than a reasonable person would provide.
- Self-neglect where an adult has resources but fails to utilize them for his/her own care.
- Exploitation where adults are victimized by manipulation of their income, resources or property.
- Sexual abuse involving many forms of sexual assault.

The House Select Committee on Aging recently estimated that over one million adults are affected by adult abuse or neglect. The most likely victims of physical abuse are females over age 75. However, younger persons who are suffering from physical or mental impairments are likely to be victims of abuse or neglect also. The number of potential victims is expected to rise partly due to the fact that the number of people over age 65 is growing rapidly as our population ages.

Families where violence occurs are likely to be experiencing great stress from the effects of alcoholism, drug addiction, marital problems, long term financial difficulties or the stress of caring for a family member. Victims of self-neglect are often isolated, without friends or family or other emotional support. In some cases they are homeless.

Forty-nine states mandate the reporting of adult abuse or neglect to law enforcement or Adult Protective Services agencies. However, these laws vary greatly from state to state. Even so, only about one out of every six cases is thought to be reported to authorities. Often when the problem of adult abuse is recognized, there may be little in the way of long term help available.

The main reason for this is the lack of federal fiscal incentives to states for programs to identify and treat adult abuse. The primary source of funding for Adult Protective Services is the federal Social Services Block Grant (Title XX). Congress provided a much needed increase in Title XX last year. This was the first major increase in Title XX since 1981 and, even with this increase, overall funding has barely kept even with inflation.

At the same time, the demand for services to at-risk adults has increased dramatically. To illustrate what this has meant at the local level, in 1983, the Los Angeles County Department of Public Social Services averaged 495 Adult Protective Services referrals per month. In 1989, the number of referrals had increased to an average of 1783 per month. This dramatic increase is the result of state legislation, enacted in 1983, which mandates the reporting of adult abuse by designated professionals. This increase, combined with little or no increase in funding for programs designed to serve abused adults, has resulted in a crisis for the system. At best, the current system is only able to serve those in greatest danger.

Urgent action is needed to develop new federal funding initiatives, increase programs to identify and treat adult abuse, and encourage public awareness of the problem. New federal funding initiatives need to be explored since the existing funding source, the Social Services Block Grant (Title XX), is fully committed. Title XX is already directed in large part towards child welfare services. In California, Title XX is also used for In-Home Supportive Services which assists eligible aged, blind and disabled recipients to remain in their own homes by providing them with a variety of domestic and personal services. This leaves limited funds available for Adult Protective Services. For this reason, we strongly support the development of a separate, permanent ongoing source of funding for Adult Protective Services.

Legislation is also needed to encourage the development of innovative programs to identify and treat adult abuse. A federal clearinghouse needs to be established to compile available information on adult abuse and disseminate this information to professionals in the field. In addition, incentives should be available to states to identify adult abuse and develop treatment programs.

Education is needed to increase public awareness of the problem of adult abuse. The public needs to know how to identify adult abuse and neglect, and professionals, and the general public need to know how to make reports to the authorities. Written materials should be available to help people identify respite care and caregiver resources, when necessary.

We see the passage of HR 220, The Prevention, Identification and Treatment of Elder Abuse Act, authored by Representative Mary Rose Oakar as an important first step in the process of developing new resources for adult abuse treatment programs. This legislation calls for the federal government to establish a national clearinghouse in the Administration on Aging for information on elder abuse treatment and prevention. Our analysis of the bill indicates the National Center would compile training materials for professionals dealing with elder abuse and would provide technical assistance to states in planning and implementing innovative treatment programs. As part of this, the bill calls for the establishment of demonstration grants for public and private, non-profit agencies to prevent and treat elder abuse. The bill would encourage elder abuse reporting by requiring states to have mandatory reporting laws in place in order to qualify for grants.

We believe that the time is right for passing HR 220 and beginning the process of identifying and helping those in our society who desperately need a voice - abused and neglected adults.

GS:mo[5/14/90]

The City of New York

DEPARTMENT FOR THE AGING
2 LAFAYETTE STREET
New York, New York 10007-1392
Prema Mathai-Davis, Ed. D.
Commissioner

Prepared Statement

of

Prema Mathai-Davis, Commissioner
New York City Department for the Aging

on

ELDER ABUSE

for

Hearing on Elder Abuse

held by

Hon. Edward R. Roybal, Chairman
Subcommittee on Health and Long Term Care
Select Committee on Aging
U.S. House of Representatives

May 1, 1990
Washington, D.C.

PREPARED STATEMENT OF PREMA MATHAI-DAVIS, COMMISSIONER NEW YORK CITY DEPARTMENT FOR THE AGING

Mistreatment of the elderly is an unusually sensitive problem because it involves such value-laden ideas as "home" and "family". The concept of home occupies a special place in American thought. We want to be seen as good, decent, caring and generous people, and we often use our homes to project those images. As for our families, we tend to see them through lenses tinted with the rosy glow of warmth and affection.

But home and family are no more immune to violence than any other aspect of American life. During the past 25 years, for example, the image of domestic tranquility has been challenged by the realities of increasing child and spousal abuse. To these we must add the abuse or mistreatment of the elderly.

Old age provides no guarantee against the forces that breed violence in the home. Child abuse and spouse beating are now common knowledge. Since the late 70's a third form of family violence, no less shocking or socially damaging has gained national awareness, -- elder abuse. In its most flagrant and disturbing form, it consists of a dependent elderly person being physically, verbally, emotionally and monetarily abused in his home by a relative (often an adult child, a spouse, other relative) or unrelated caregiver.

I would like to share with you the story of Mrs. R a 69 year old white, divorced female who resides in her home in Staten Island. She receives SSA, SSI, Food Stamps and Medicaid.

Mrs. R's 31 year old son resides with her. Mrs. R is hearing impaired (she wears a hearing aid), suffers from degenerative arthritis and a heart condition.

In June, 1981 when she was the victim of a burglary, Mrs. R became known to the Community Agency for Senior Citizens (CASC), a neighborhood-based program which receives funds from our Department to provide a variety of services to seniors on Staten Island. CASC staff responded by providing counseling, lock and window bar replacement and linkage with the New York State Crime Victims Board.

Mrs. R sought services again in 1984 and 1985 when she was again burglarized. CASC staff assisted the victim in replacing three windows, securing a cylinder change and assisting with application to the New York State Crime Victims Board.

Then, in 1986 Mrs. R spoke with the CASC worker of difficulties she had experienced with her adult son who had begun drinking at age six and using drugs at approximately age 12. When under the influence of drugs he became physically abusive towards her. At one time he attempted to choke her while under the influence of angel dust. Her son also had a criminal record. He had been in five different correctional facilities by age 29. Although he had tried several drug treatment programs, he did not complete these programs. Moreover, he had tried to commit suicide once while participating in a drug rehabilitation program and twice while in correctional facilities.

The CASC worker provided emotional support and counseled Mrs. R on safety procedures as well as encouraged her to seek an order of protection in preparation for her son's release from prison. Mrs. R declined seeking an order of protection at that time.

Upon his release from Sing Sing Correctional facility, Mrs. R began to experience victimization from her son on a regular basis. She was threatened when money was withheld, and, if she was absent from the home, articles of value and cash were removed by the son. Mrs. R suspected her son was returning to his habit of drug and alcohol abuse.

Lock cylinders in the house were changed to prevent access by the son to the home. Emergency procedures were outlined. Mrs. R was encouraged to seek an order of protection and press charges against her son. Mrs. R refused. She did not want to give up on her son or the possibility of his complete rehabilitation. Contact was made with his parole officer and both CASC and the parole officer continued to encourage Mrs. R to seek an order of protection to exclude him from the household.

The CASC worker also continued to provide ongoing support and linked the client with a local Al-Anon group. CASC encouraged Mrs. R to seek more comprehensive counseling concerning her son's addiction and she did receive some counseling through a local Mental Health Center.

But the victimization continued and in 1988 Mrs. R agreed to secure an order of protection but then changed her mind and would not pursue this option. Her son was all she had in the world and she could not give up on him. She was convinced that the correctional facilities had failed to address her son's problems and the drug rehab programs were of little value to her son because they employed drugs as treatment. Therefore, she felt she must do everything possible to provide the opportunity for her son to change his lifestyle.

The CASC worker continued to provide support, educate and assist Mrs. R to secure her home, protect herself and to encourage her to press charges against her son.

When jewelry was removed from her home and she found pieces in a local jewelry store, Mrs. R decided to press charges. But again, she changed her mind and dropped the charges.

The victimization continued. In November of 1988 the son threatened to hit Mrs. R. Mrs. R left the home, called the police and had her son arrested. The CASC worker responded with support, security changes and encouraged Mrs. R to press charges. Mrs. R agreed and then a third time refused to do so. In December, 1988, Mrs. R's son was returned to a correctional facility for a few months on shop lifting charges. Upon his release he returned to his mother's home.

Then, Mrs. R's son was arrested in April, 1989 for burglary. This time Mrs. R refused to post bail and sought and received an order of protection. However, the son's father (divorced from Mrs. R and residing in another State) arranged for bail and the son was released.

No known incidences occurred between April 1989 and June 1989. However, in June, 1989 Mrs. R's son was arrested for grand larceny auto and sentenced to a correctional facility. From that point on CASC staff provided ongoing support and assistance and in February, 1990 CASC staff began working with Mrs. R to prepare her for the release of her son from prison.

Victimization began again upon the son's release in March, 1990. Charges were again filed against the son but were dropped at the urging of his father.

Mrs. R agreed to seek and is currently receiving mental health counseling. Her son is presently living with her and is waiting for acceptance into a rehabilitation program.

We can only expect that this terrible cycle of suffering will go on unless action is taken to address elder abuse. Moreover, Mrs. R is but one case.

Our Department has recently completed a study entitled "Elder Abuse: A Profile of Victims Served by the New York City Department for the Aging. This study entailed an analysis of intake records from our Senior Security Programs of over 800 cases of abuse reported to the Program from January 1987 to January 1989.

The study findings indicate that the majority of the victims were females between 60 and 99 years old. Victims were both older and more female than the elderly population in New York City. While the victims were female, more than half the alleged perpetrators were males between 13 and 96 years old.

Moreover, almost two-thirds of the perpetrators were relatives, of whom over one-third were adult children. Although financial abuse was the most frequently reported type of abuse, mistreatment took a variety of forms (financial, physical, psychological, and neglect) and most often occurred in combinations of these. Almost two-thirds of the cases involved more than one type of abuse. Furthermore, one in five of the elderly were victims of three or four types of abuse. Cases of abuse are referred to the Department from a number of different sources; the most frequent being agency referrals. Most of the cases, however, were not reported to the police.

Adult children and agency-based perpetrators were found more likely to be involved in financial abuse. Although spouses were infrequently involved in any cases of abuse, when they were, they were far more likely to be involved in acts of physical abuse. As for children, there was no difference in the types of abuse engaged in by sons and daughters. Moreover, not only did relatives as a group comprise the overall largest category of perpetrators, they also were involved in an even greater proportion of abusive acts than their numbers represent.

In regard to police involvement, cases in which three or four kinds of abuse occurred were no more likely to be known to the police than those cases where one or two different types of abuse were alleged to have occurred. The police did seem, however, to have more involvement in cases of physical abuse than in other types of abuse.

The study also found that different referral sources tended to report specific types of abuse. For example, organizations were more likely to report cases of physical or financial abuse, whereas, victims who directly called for assistance were more likely to report cases of psychological abuse. Inasmuch as non-relatives comprised most of the alleged perpetrators of psychological abuse cases, one might conjecture that victims felt freer to report them than to report cases of abuse within their own family.

Although the reported cases were not substantiated by the Department and, therefore, must be considered alleged cases of abuse, these data nonetheless emphasize the emergence and importance of this special group of victims.

If we fail to address these problems of elder abuse, including violent mistreatment of the elderly, in all likelihood, as the older population grows in numbers, we will see a parallel burgeoning in the numbers of those who are abused.

Domestic mistreatment of the elderly is a phenomenon with identifiable causes and consequences. If we are to prevent such mistreatment, we must be aware of its basic ingredients.

The first of these is the nature of the relationship involved. There is often a level of dependency between the abused elder and one or more younger adults. The victim and perpetrator may live together, frequently in the elder person's own home. However, abusers can also include neighbors or landlords of an elderly victim who lives alone, or relatives who exploit the victim's resources without having a truly interdependent relationship with the victims.

In terms of reported victims, older women are more often cited simply because their numbers are so much greater. But there is no clear evidence at this time that one sex is more vulnerable to victimization then the other. Indeed, indication that elderly men are at as great risk of mistreatment as elderly women.

The Department for the Aging is seeing abuse cases at increased rates. More and more families, physicians, social workers, the police and the abused themselves are turning to the Department for help. The cases are complicated and intensive. The possible reasons for elder abuse and/or neglect appear to be: 1) the psychological state of the perpetrator, 2) dependency and/or changed relations between the abused and the abuser, 3) external stress, 4) social isolation, and 5) intergenerational transmission of violence ("cycle of violence").

With heightened public awareness of elder abuse, and an ever increasing demand from the community for services, the need for a specialized service is clear. In response to this, the Department for the Aging in 1986 hired an Elder Abuse Specialist. Since December of 1986, the specialist has provided direct and case consultation services to over 1,000 victims of elder abuse. Because of her intervention, we have ascertained that many services are usually needed, by victims including counseling, entitlement evaluations, protective services, police intervention, hospital and doctors examinations, residential facilities placement, mental health care, legal consultation, and court procedures. In some cases simple solutions such as temporary respite care for the caregiver is an appropriate remedy, while other situations require a more complicated plan for their resolution.

However, as we have pointed out, elder abuse is a growing problem and our resources at this time cannot adequately address the needs for assistance we face. Only through a national program, which gives both federal recognition to the need and support to meet it will we be able to help these saddest of victims. We believe that the time to act is now. The 1987 reauthorization of the Older Americans Act created a new provision for elder abuse prevention services under Title III but funds were not appropriated. Certainly with reauthorization in 1991, Congress has a ready-made opportunity to act on this matter of national concern. If we fail to address this growing problem, we as a nation will be guilty of having failed the most vulnerable of our elderly.

GUIDELINES AND COMMENTARY FOR LEGISLATION TO PROHIBIT PATIENT AND RESIDENT ABUSE

NATIONAL ASSOCIATION OF ATTORNEYS GENERAL
AND
NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

September 1988

FORWARD

The first state Medicaid Fraud Control Units were established 10 years ago, and while the remarkable success of these Units in discovering and prosecuting fraud by Medicaid providers is widely recognized, it is less well known that they have jurisdiction as well over complaints of patient mistreatment in residential health facilities that receive Medicaid funds. As a result of numerous investigations and a decade of cumulative experience among Medicaid Fraud prosecutors, we have come to realize that abuse, neglect and mistreatment of patients in health care institutions is a problem of greater magnitude than had been previously known.

Patient abuse can be classified into several categories. Providing inadequate medical or custodial care or creating other health risks to the patient may constitute patient neglect. Physical abuse includes acts of violence such as slapping, kicking, hitting or punching a patient and sexual abuse. Fiscal abuse includes the misappropriation of patients' personal funds such as commingling patient and facility funds or using patient funds to pay for facility operations.

It is particularly important for state governments to aggressively tackle the problem of patient abuse, since those who find themselves in these desperate situations may well have no one to turn to and no ability to protect themselves.

Unfortunately, the ability of state Medicaid Fraud prosecutors to indict and convict those who commit patient abuse crimes has been severely hampered by the lack in most states of statutes which specifically address the problem. Such statutes are needed in order to define clearly the duty of health care facilities to protect their patients from harm and neglect and to impose criminal penalties for the failure to carry out that duty. Moreover, such statutes must address certain evidentiary problems frequently present in patient abuse situations and clarify the respective legal jurisdiction of the various agencies within state government which oversee institutional care.

In order to encourage states to enact such patient abuse statutes, the National Association of Attorneys General (NAAG) and the National Association of Medicaid Fraud Control Units (NAMFCU) have cooperatively developed Guidelines intended to assist states in drafting and enacting legislation to protect patients from abuse and to facilitate effective prosecution of patient abuse crimes.

These Guidelines are accompanied by a commentary and by a resolution NAAG adopted at its 1988 Summer Meeting which encouraged states to adopt patient abuse legislation, using the Guidelines as a model.

Both Associations gratefully acknowledge the skilled work of the NAMFCU Drafting Committee chaired by Special Deputy Attorney General J. Michael Carpenter, Director, North Carolina MFCU, Assistant Attorney General Russell Stoddard, former Director, Alabama MFCU, Assistant Attorney General Paul Coval, Director, Ohio MFCU and Assistant Attorney General Michael Schwartz, Washington MFCU. Both Associations also gratefully acknowledge the valuable comments, suggestions and advice received on the Guidelines from the NAAG Patient Abuse Working Group under the leadership of Washington Attorney General Ken Eikenberry. Arkansas Attorney General Steve Clark, Indiana Attorney General Linley E. Pearson and Vermont Attorney General Jeffrey Amestoy provided their invaluable insight as members of the NAAG Patient Abuse Working Group.

Protection of the sick and elderly and delivery of the highest quality health care to those residing in health care institutions is a priority of state Attorneys General and Medicaid Fraud Control Units. However, obstacles to deterring and punishing those who abuse the elderly and infirm remain, and we strongly encourage each state to strengthen its efforts to prevent patient abuse by using these Guidelines to adopt comprehensive and cohesive patient abuse legislation.

Robert Abrams
Attorney General of New York
President, National Association
of Attorneys General

David W. Waterbury
Assistant Attorney General
Director, Washington State
Medicaid Fraud Control Unit
President, National Association of
Medicaid Fraud Control Units

NATIONAL ASSOCIATION OF ATTORNEYS GENERAL

Adopted

Summer Meeting
June 19-22, 1988
Hilton Head, South Carolina

VIII

RESOLUTION

TO ENCOURAGE STATES TO ENACT LEGISLATION TO DEAL WITH PATIENT AND RESIDENT ABUSE IN HEALTH CARE FACILITIES

WHEREAS, a decade of investigation of patient and resident abuse, neglect, and mistreatment by state Medicaid Fraud Control Units and other agencies of various Attorneys General has established that patient abuse crimes pose a significant threat to the safety and well-being of the elderly and sick residing in health care institutions; and

WHEREAS, such prosecutions have been significantly hampered by the lack of specific state statutes addressing the unique aspects of patient abuse crimes, defining the duty of health care facilities to protect their sick and elderly residents from harm and neglect, resolving the evidentiary problems specific to patient abuse crimes, and coordinating the responsibilities of the various agencies within state government overseeing institutional care; and

WHEREAS, a limited number of states that have enacted specific patient abuse statutes have seen marked improvements in the abilities of their Attorneys General, their Medicaid Fraud Control Units, and other state law enforcement authorities to prosecute crimes of patient abuse, protect the victims of patient abuse, and deter potential wrongdoing against them; and

WHEREAS, protecting the interests of the sick and the elderly is a priority of the National Association of Attorneys General and its individual members; and

WHEREAS, the National Association of Medicaid Fraud Control Units and a NAAG Working Group of Attorneys General have cooperatively developed guidelines to assist the states in developing and enacting patient abuse legislation within each state's individual legal structure;

NOW, THEREFORE, BE IT RESOLVED BY THE NATIONAL ASSOCIATION OF ATTORNEYS GENERAL THAT:

1) each state is encouraged to enact specific patient abuse legislation to help protect the sick and elderly residents in health care institutions and to facilitate effective prosecution of crimes committed against them; and

2) each state is encouraged to use the patient abuse guidelines developed by the National Association of Medicaid Fraud Control Units and the NAAG Working Group when developing such legislation; and

3) each state is encouraged to stregthen its efforts to prevent patient abuse and related crimes in health care institutions; and

4) the Executive Director is authorized to transmit copies of this resolution and accompanying patient abuse legislation guidelines to appropriate state and federal officials and other appropriate officials, associations and individuals.

COMMENTARY

Introduction

Responding to the growing national concern about patient and resident abuse, the Legislative Committee of the National Association of Medicaid Fraud Control Units (NAMFCU) in conjunction with the Patient Abuse Working Group of the National Association of Attorneys General (referred to jointly as "the committee," *infra*), commissioned this effort to produce legislative guidelines to address this important subject. While a number of states have legislated in this area over the last several years, others have not, leaving dependant individuals protected only by traditional criminal laws.

Both the NAAG Working Group and NAMFCU acknowledge the need to formulate special legislation to best protect individuals who must depend on others for their care and well-being. While the majority of those individuals and business entities that provide care to the elderly and the mentally and physically disabled do so in a quality manner, some do not. Meaningful deterrents, sanctions, and remedies for physical abuse and neglect can be accomplished without infringing on the normal and appropriate business and professional practices of those discharging their responsibility for the care of others. With a clear recognition of the critical importance of protecting the elderly and infirm to the full extent of the law, these guidelines are proposed for the consideration, analysis, and adoption by the various states.

Research discloses that the laws of those states who have enacted specific statutes are far from uniform. Some states have adopted comprehensive laws, however, most states have not done so. For example, the laws of several states prohibit intentional assaultive behavior but fail to adequately address criminal neglect. In others, the lack of a proper reporting system for allegations of abuse and neglect prevents, or at least impairs, an appropriate criminal justice response. Conversely, some states have adequate reporting laws but inadequate criminal sanctions. In short, there is substantial variation among the states in the protections provided to patients and residents who are the victims of abuse.

These guidelines are designed to provide to states without relevant laws a framework upon which to base proposed legislation. In states that also have inadequate statutes, portions of these guidelines may serve to address existing shortcomings. The guidelines are deliberately broad and encompassing. It is expected that their scope and language will be tailored to meet the specific problem areas existing in each state. Considerable care must be taken to incorporate the proposed provisions with any existing state protections afforded to patients and residents. For example, it is assumed that each state has appropriate statutes for the punishment of major violent crimes (*e.g.* murder, rape, sexual offense, etc.) regardless of the status of the victim. If existing protection is inadequate, or if increased protection is sought for patients and residents of a care facility, a corresponding effort should be made to revise those statutes accordingly.

The guidelines encompass some nine sections: definitions; offenses of patient and resident abuse and exploitation; reporting requirements; collateral consequences (license revocation or suspension); treatment in conformance with right to natural death; treatment based on consent or religious belief; civil cause of action; severability; and, no repeal nor preclusion provisions. The committee has included a separate commentary addressing each section of the guidelines. Again, it should be emphasized that the scope of the guidelines is purposefully broad requiring that attention be focused toward the consideration of individual provisions with the unique circumstances existing in each state considering the enactment of legislation in this area.

Section 1: *Definitions*

The terms used throughout the Guidelines to Prohibit Patient and Resident Abuse have as their definition the meanings ascribed to them by common usage, except when defined therein. As to the defined terms, the object was to allow each adopting state to integrate this legislation into its existing criminal code by providing alternative wordings on its specific provisions. For example, the definition of "abuse" provides for adopting states the choice of whether physical "pain", physical "injury" or physical "harm" is to be the standard used to define this term. A state may thus choose the term that best comports with the standards it has already adopted with respect to other criminal acts of an assaultive nature. It is believed that the desired integration will be more readily achieved when the terms selected by a particular state for use in the legislation are terms that have already been defined through the adopting state's statutory or case law. In order to accomplish this, the guidelines provide for alternative word choices in numerous provisions of this legislation. (*E.g. likely to /could*; *recklessly/culpable negligence*; etc.)

The same desire to integrate the guidelines into the existing law of a particular state requires deference to existing law regarding the definitions of several specific terms. The committee believes that many of the terms used in the guidelines have been defined by each state's legislature or judiciary and that adoption of these guidelines as legislation may be more likely if they do not carry definitions foreign to a particular state. For that reason the terms "assault", "knowingly", "physical harm", "psychological harm", "recklessness" or "culpable negligence" and "serious physical harm" were thus left undefined. Each adopting state is encouraged, therefore, to incorporate its definitions of these terms when considering legislation based on these guidelines.

The term "abuse" has been defined to encompass a variety of acts likely to threaten the physical or psychological well-being of patients and residents of care facilities. The definition includes acts which constitute assault and battery under existing state law, as well as acts which constitute the infliction of physical or psychological injury. In some states, assault statutes require that a high degree of physical harm be shown in order to constitute the offense. To avoid excluding from the scope of these guidelines lesser assaults than would satisfy the elements of such statutes, the guidelines include subsection (1)(b) to Section 1. With the inclusion of this subsection, any knowing or reckless/culpably negligent conduct which inflicts harm or which could inflict harm is within the scope of the prohibitions of the guidelines. As indicated, proper use of the guidelines requires consideration of each state's individual circumstances and needs. In this area, states may choose to include or omit the concepts/language of (1)(a) and/or (1) (b) depending on these particular needs.

Subsections (1)(b) and (1)(c), both address physical conduct that causes, or is likely to cause physical or psychological harm. Through the use of the included qualifying language, health care providers performing their legitimate duties/functions will not be subjected to criminal accountability where such duties/functions may have caused incidental pain or discomfort. An example: Insertion of an intravenous tube can be painful; a resident or patient could complain or even demand criminal charges for "conduct which causes physical pain"; under the language of these subsections, however, such a complaint would be unfounded, for the conduct would clearly fall within the exception for "treatment or care. . . in the furtherance of the health and safety of the patient or resident". The conduct which caused the pain, the insertion of an I-V tube, should obviously not be, and under this language could not be, grounds for a criminal complaint.

The term "abuse" also covers, under subsections (1)(d) and (1)(e), conduct which constitutes the failure to provide a patient or resident with sufficient care, including that which is warranted by his condition or the plan of care prescribed by his physician. These provisions encompass conduct which, in some states, is labeled criminal neglect. The object in including these provisions was to make nonfeasance with respect to patients and residents of care facilities a criminal offense. As the elderly or disabled become more dependant on others for their care, it becomes increasingly important for individuals who accept the position of trust as caregivers to the needful to be held accountable for neglecting those in their charge. Failure to provide the care and treatment necessary to maintain the welfare of those who depend on that care is every bit as dangerous and harmful as intentional assaultive behavior. These sections set forth the principle that such acts of neglect be treated accordingly.

Additionally, the term "abuse", in subsection (1)(f), refers to the inappropriate use of a physical or chemical restraint, medication or isolation. The potential for misuse that is presented by the ready availability of physical or chemical restraints and medications in care facility settings is great. Numerous cases have been documented where restraints were used because they were a cheaper method of controlling residents and patients than maintaining adequate levels of trained staff. This conduct must be prohibited. The guidelines do not criminalize the proper use of these items or practices. Rather, they clearly define the situations in which the use of these items and practices shall be deemed criminal-instances where use is dictated by convenience of staff or financial considerations of the facility as opposed to use based on the health and safety of patients and residents.

The definition of the term "care facility" in subsection (2) was drafted to include the widest range of facilities in which persons dependent upon others for their health or resident care needs might be found. The guidelines express the intention that no distinctions with respect to facility size or type should be made regarding the offense of abuse. Any of the forms of harm defined as abuse should be made criminal without regard to the particular settings in which they occurred. Consistency dictates that identical harms should carry the same criminal penalty in a nursing home as in a private home or other care facility. This is especially true with regard to non-institutional settings in light of the fact that there currently exists in many states a policy, directed by quality of life and financial considerations, to provide in-home care for as long as possible and to postpone placing individuals in nursing homes or other institutional settings. As a consequence, many people who would have been in a residential setting, subject to the protections of regulatory and criminal law, are still at home and without such protection. Accordingly, the coverage of the term "care facility" was intentionally made very broad. It includes hospitals and every other type of care facility, even private homes.

An additional reason why states might consider adopting the definition of "care facility" in the broad form in which it appears relates to the impact that excluding certain facilities might have on the availability of professional staffs. The concern exists that differences in criminal penalties for the same abusive conduct based upon the type of facility in which it occurs might deter nurses or other health care professionals from seeking employment in those facilities to which such higher criminal prohibitions would apply. By including the widest range of care facilities within the definition of "care facility" this potential problem is eliminated. The record clearly supports the fact that patient and resident abuse is not confined to institutions.

Exploitation as proscribed by the guidelines and defined in subsection (3) refers to conduct which is designed to take financial advantage of patients and residents of a care facility. Given the vulnerability of patients and residents of care facilities to financial misdealings by their caregivers, such conduct should be criminalized. The inclusion of the requirement of express voluntary consent on the part of the patients and residents, or their representative if incompetent, to the handling of their assets by caregivers provides protection against coercive or intimidating behavior. Inclusion of a prohibition against exploitive behavior complements the objective of the guidelines to provide maximum and comprehensive protection to persons residing in care facilities.

Subsections (5) and (10) define "patient" and "resident" as one who receives treatment or resides in a care facility respectively.

Subsection (6) defines "person" broadly to include not only any natural person but also any business entity. The guidelines include the concept of vicarious criminal liability. This is particularly the case in abuse prosecutions predicated upon institutional conduct constituting patient or resident neglect.

Section 2: *Offenses of patient or resident abuse and exploitation*

The offense of patient or resident abuse includes both intentional conduct and unintentional acts performed in a reckless or culpably negligent manner. States using these guidelines should look to their own statutory or case law for the term or terms used to describe reckless or criminally negligent conduct and substitute this language where appropriate. The guidelines are based on the premise that any law which specifically prohibits patient abuse must provide penalties for both intentional and reckless behavior.

Within the area of criminal law, culpability and punishment are often determined by a combination of assessing the perpetrator's state of mind and the amount of harm caused, or which could have been caused, by the perpetrator's actions. The guidelines reflect these traditional considerations through the use of both of these factors in creating the various levels of culpability.

Accordingly, the most severe form of patient or resident abuse is the intentional infliction of "serious physical pain/injury/harm" [Subsection (3)(a)]. This philosophy is consistent with the degree of criminality most commonly ascribed to such behavior and parallels not only enacted patient abuse provisions but also most crimes involving danger to the person. The term "*serious physical* pain/injury/harm" denotes an actual physical injury of a more severe nature or higher degree.

This is distinguishable from "*physical* pain/injury/harm" which is considered a less serious injury resulting in a lesser degree of criminal responsibility. [Subsection (3)(b)]. These terms are borrowed from the statutory language generally encountered in the definitions of assault and homicide and, occasionally, in defenses involving justification or excuse. By far, their most common use is to distinguish degrees of assaultive behavior. Each state should substitute the familiar term of art normally used in such instances.

Subsection (3)(b) also includes the intentional infliction of psychological pain/injury/harm as a punishable offense. Several state patient/resident abuse statutes, either enacted or proposed, contain prohibitions and punishment for psychological harm. Consequently, the guidelines include such a provision. However, in deference to the wide range of definitions and terms of art currently in use in this area, the guidelines do not contain a definition of "psychological pain/injury/harm". Therefore, it is contemplated that each state will adopt its own definition or objective criteria to accommodate this provision.

Unintentional conduct is punished pursuant to Subsections (3)(c) and (d). Unintentional conduct performed in a criminal, i.e., reckless, criminally negligent, culpably negligent manner which results in serious physical harm is punished to the same degree and to the same extent as the intentional infliction of physical or psychological harm [Subsection (3)(c)]. This is consistent with the aforementioned discussion regarding *mens rea*, the nature of the injury, and the weight each should be accorded in determining the degree of criminal responsibility.

Subsection (3)(d) addresses the unintentional infliction of physical as well as psychological harm. Since this section contemplates criminally negligent or reckless conduct which results in injury of a degree or kind less than that described in Subsection (3)(c) above, the corresponding punishment is also less severe. This section provides for the most lenient punishment of any of the patient abuse activities which result in injury to the victim.

Subsection (3)(e) provides for the punishment of conduct, whether intentional or unintentional, which meets the definition of patient abuse but does not result in any injury to the victim. In this case, there is no distinction made with respect to intent and the focus of culpability is on the act committed. This section embodies the philosophy underlining the guidelines, that people dependant upon others for care and treatment must be protected by the criminal law from abuse arising out of purposeful or neglectful conduct. Under this scheme, it is the conduct of the caregiver that is of critical importance. Regardless of the creation of pain or harm, if the caregiver neglects the health and safety of those who are dependant, he or she must be held accountable. The guidelines contemplate that the punishment in these circumstances be treated as a misdemeanor of the highest grade or degree.

Subsection (4) makes the unpermitted expenditure, diminution, or use of the property or assets of a patient or resident of a care facility a crime. This is in recognition of concerns expressed that current laws often do not adequately deter unscrupulous care facility operators from converting patient or resident resources to their own benefit and enrichment. Subsection (4)(a) suggests that the punishment for a violation of this subsection be a felony of the same kind or degree as the punishment for the intentional infliction of physical or psychological harm.

Section 3: ***Reporting requirements***

Subsection (1): "Person" includes any individual who is directly employed by the facility or any professional who comes into contact with a resident or patient.

The basis for reporting is direct knowledge or "reasonable cause". This language provides for an objective standard which allows for an exercise of discretion in all cases, including those where the allegation originates with the resident. Because the language includes an objective standard, allowing for independent assessment of whether or not "cause" existed that would require a report, individuals or institutions who fail to fulfill their obligations to report will not be able to avoid accountability by claiming ignorance. By the same token, those who decide not to report apparently spurious or obviously false claims will not be subjected to criminal sanctions, as they will be protected by the same objective requirement that "reasonable cause" exist before a report must be made.

The guidelines address the issue of *what* should be reported. The reporting requirement in the guidelines is focused only upon acts that constitute crimes as defined by the abuse law and other existing state laws. The reasoning behind this narrow scope is threefold: (1) an acknowledgment of the professionalism of health care providers and the belief that given proper, understandable guidelines, appropriate choices will be made when considering what to report; (2) a desire to avoid an inundation of reports and the system overload that would follow, a situation that could mean lack of resources to address even the most serious cases; and (3) a desire to increase the quality of referrals and ability to prosecute failures to report by having those referrals based on apparent criminal conduct victimizing a patient or resident.

Subsection (2)(a)(b): The reporting requirement will operate on a two-track approach:

> (i) because all reports will involve a belief that a criminal act has occurred, police should be notified immediately;
>
> (ii) because all reports involve quality of care issues and the welfare of the resident(s), the department responsible for oversight should also be notified so that they can process the case according to applicable state regulations.

Subsections (2)(b), (2)(c) and (4) require inclusion of specific language describing the appropriate state agency to receive the reports. Factors which may be considered include:

- How the social service department/single state agency is set up;
- Where the regulator function capable of responding to complaints exists within the department;
- Whether or not county or state ombudsman program(s) exist capable of responding to complaints;
- Whether or not a complaint hotline exists;
- Additionally, states may wish to consider formalizing (or establishing) relations between the single state agency and the MFCU by requiring the MFCU to be contacted upon discovery of abuse, etc. Notification of the MFCU could be primary (with police) or secondary (with or from the single state agency), depending on existing decisions of jurisdiction.

Subsection (3): The guidelines require that reports be from identified parties. While anonymous reports may encourage reporting by offering a level of protection to the individual, the actual result expected would be numerous reports of poor quality with limited ability to verify and investigate. The guidelines are based on the expectation that agencies conducting investigations can afford employees protection (at least until charges are filed) by maintaining confidential files, a practice that is currently widespread.

In a related area, the guidelines do protect employees by not requiring that owner/operators be given a copy of employee reports. While concrete proof of "notice" may be helpful in the event that becomes an evidentiary issue in future prosecutions, the guidelines contemplate that "notice" can be sufficiently established by showing that an agency responded to a complaint with an investigation and that this investigation would necessarily have been brought to the attention of the owner/operator. This would be especially true if the complaint were well founded and corrective action ordered as a result. Therefore, with the "notice" issue satisfied and employee protection an important consideration, requiring the forwarding of a written copy was not included in the guidelines.

Subsection (5)(e): This subsection was written in "generic" form. That is, no distinction was made whether these provisions were to be part of the resolution of a criminal action under (5)(d) if they were to be part of a separate civil action. This determination is, obviously, dependant on state law and whether or not these types of sanctions can be included in a criminal action. Individual states should add whatever additional language is needed to conform this section with existing state law.

Subsection (6): The abrogation of privileged communication and preclusion of orders of incompetency (where state law make certain individuals incompetent because of their confidential relationship with another) is necessary to allow those covered by privilege laws to report their knowledge of abuse, exploitation and other criminal acts.

Also, if applicable, states may wish to specify any established ethical canons that would conflict with the abrogation of privileged communications set forth in this subsection.

Subsection (7) and (8): The guidelines set forth the position that a substantial penalty is appropriate where supervisors or administrators involve themselves and their facilities in blocking the ability or desire of others to report cases of abuse, etc., as required by statute.

Subsection (8)(a)(3): This subsection is not intended to address the issue of manipulation or destruction of internal documents (patient charts, medication orders, pharmacy records, etc.) carried out to avoid detection of improper action in a facility. It is assumed that current state laws regarding obstruction or tampering will adequately address this fact pattern. What this subsection does address is the possibility that a supervisor/institution may allow a subordinate employee to report, but in forwarding the report to the appropriate agency (particularly on behalf of night shift employees) may so alter or manipulate the report as to render it useless.

The reporting requirement plays an important part in protecting patients and residents from the increasing dangers of ongoing abuse, neglect, or exploitation. It is a significant wrong to avoid the duty created by statute to report such cases of abuse, neglect, or exploitation. But it is an extraordinarily unconscionable and unacceptable act for a supervisor or institution to purposefully endanger the safety and health of patients and residents by preventing an employee from making a report that could initiate a needed investigation and intervention by the state. Such acts require a severe response from the criminal law.

Subsection (9): The guidelines include this provision notwithstanding the fact that the definition of "facility" including private homes, may render this section difficult to enforce. The provision, however, is important. While selective enforcement is not advocated, there is an appreciation that professional facilities will be scrutinized for compliance within the context of normal regulation of the industry.

Section 4: ***Collateral consequences of conviction; mandatory revocation or suspension of license.***

Subsection (1) requires the clerk of the convicting court to report the conviction of any licensed or registered professional person or entity for any offense arising under the guidelines (abuse, exploitation, or failure to report such offense or other criminal offense) to the appropriate state board of licensure or registration. A certified copy of such judgment shall constitute sufficient evidence of the conviction. The coverage is intentionally broad and is designed to provide the licensing or registration authority with notice of such conviction so that appropriate action may be timely taken. The terms "professional person or entity" were chosen to insure coverage not only of a licensed professional in the traditional sense (*e.g.* medical doctor, nurse, nursing home administrator, etc.) but also of the entity itself (*e.g.* nursing home or other institution) which holds a license from the state and is the subject of a conviction. In states where nurses' aides are licensed or registered, the provision of this section apply.

Subsection (2) provides that the appropriate state board of licensure or registration retains all authority to discipline its licensure or registrants subject to certain mandatory minimum periods. This approach permits the respective board to suspend or revoke the license or registration for any period, including permanently, in its discretion. However, such discretion is limited by subsection (2)(a) and (2)(b) as the minimum period of revocation or suspension for persons or entities convicted of abuse, exploitation, or failure to report as those offenses are defined in the guidelines. For a conviction of abuse or exploitation, the period of suspension or revocation shall be not less than three (3) years. For a conviction of failure to report under subsection (7)(b) of Section 3 of the guidelines, the period of suspension or revocation shall be not less than six (6) months. For a conviction of failure to report under subsection (8)(b) of Section 3 of the guidelines, the period of suspension or revocation shall be not less than twelve (12) months.

Subsection (3) makes it clear that a conviction of any licensed or registered professional person for any criminal offense where the victim is a resident or patient of a care facility triggers the provisions of Subsections (1) and (2) of this Section. This insures that if a state chooses not to include within its definition of "abuse" under the guidelines an existing criminal offense (*e.g.* rape), such conviction will nonetheless be subject to the same mandatory minimum periods of revocation or suspension.

Section 5: *Treatment on conformance to right to natural death/and*

Section 6: *Treatment based on consent or religious belief*

Section 5 and Section 6 both apply to affirmative defenses when a resident, or a person legally authorized to represent a resident, declines treatment. Depending on state law, Section 5 may be superfluous and states may wish to delete it.

The language of the introductory sentence of subsection (6) should be read to clearly convey the intent of the guidelines that sub (c) is required in all events, and that subsections (a) and (b) are alternatives. The choice between sub (a) or (b) depends on the existence of a religious basis with an "informal consent" as allowed for in sub (b).

The language of Section 6 reflects three underlying issues;

(i) The defense is affirmative; the defendant must bear the burden of production and proof of evidence. This system avoids putting the prosecution in the position of having to disprove the existence of facts that would constitute a defense as elements of the crime;

(ii) Subsections (a) and (b) include religious considerations (sub (b)) and a change from the formal 'consent' requirement in sub (a) to 'wishes' in sub (b). [*Note*: If "informed consent" is an applicable term of art in the state, it may be used in place of "written" consent.] The guidelines contemplate that in cases where a third party (most likely a relative) is acting on behalf of the resident and in accord with religious beliefs, it would be inappropriate to require a formal/written consent. The term 'wishes' would also include cases where 'consent' was obtained.

(iii) Whatever action/inaction exists, it must in all cases be consistent with state law. This was left non-specific in recognition of the fact that states have moved forward in the area of 'right to die' by statute and case law or some combination of both. In the face of constant change in this area, it was determined that the best method of addressing this area of law was to leave the language 'generic', thus providing for the automatic inclusion of current and future developments.

The guidelines address "religious" considerations. Though potentially superfluous, if existing state law as depicted in subsection (c) would include religious issues, the guidelines contain specific language on the issue to allay any fears of religious groups.

Section 7: *Civil cause of action*

The guidelines advocate a specific grant of jurisdiction to state Attorneys General for a civil cause of action or a regulatory action in the quality of care area. This jurisdiction would exist concurrent with, but independent from, any authority within the single state agency or other state regulatory body with jurisdiction over care facilities.

This section is premised on the belief that regulation of the industry is, in many states, inadequate. This inadequacy may exist for a variety of reasons, but appears in the form of too few regulatory actions or fines/penalties too small to have an impact. The expectation contained with this provision of the guidelines is that independent authority within an Attorney General's office would be exercised without the constraints which may exist within the regulatory agency.

The inclusion of a civil cause of action fits well within the goal of the guidelines: to effectively bring the investigatory powers, punishment, and deterrent values of the criminal law forward to protect patients and residents and to insure their health, safety, and appropriate care. To that end it must be recognized that while a powerful force, the criminal justice system is not omnipotent. There will certainly be occasions when a criminal prosecution cannot be maintained. This may occur as a result of the unavailability of key evidence, the absence of a crucial witness, witness incompetence, or, for other myriad reasons. On occasion, proof meeting the criminal burden of proof beyond a reasonable doubt cannot be obtained. However, the investigation may have developed sufficient evidence to meet the civil preponderance of evidence standard. The guidelines would fall short of their stated goal if an investigation were to reach such a point without providing an alternative remedy.

A civil action could also be useful in situations where immediate relief is needed for the protection of the residents and patients but the investigation has not become ripe for criminal action. Again, the civil jurisdiction would be an extremely useful adjunct to the criminal track.

Civil jurisdiction provides a key element in the overall effort to protect the health and safety of our elderly and dependent population. That element is the ability to utilize a single integrated office with civil, regulatory, and criminal components to address the problem of abuse, neglect, or exploitation of our elderly and dependant population. Inclusion of civil jurisdiction allows for an Attorney General's office to fashion a coordinated approach, and thus provide the best opportunity for insuring the safety and welfare of its citizens.

Other concepts, apart from creating an independent civil cause of action by the Attorney General, were discussed by the committee. One state has enacted an interesting statute which the committee believes may be of benefit to those states considering legislation in this area. The State of New York has created a private cause of action on behalf of any patient who is subject to a deprivation of any right or benefit by a residential care facility. This cause of action extends to any right or benefit created or established by contract, or arising under any state or federal statute, code, rule or regulation. Compensatory damages are available to any patient injured as a result of such deprivation. Punitive damages may be assessed where the deprivation is found to be willful or in reckless disregard of the patient's rights. The statute also provides for injunctive and declaratory relief, authorizes the bringing of class actions, and for the award of attorneys fees to successful litigants. This action exists independent of any regulatory or other private civil action which may be brought. *See*: New York Public Health Law § 2801-d (McKinney's 1985).

This type of civil action, especially if extended to permit advocacy groups to bring lawsuits on behalf of aggrieved patients and residents, would not only significantly broaden existing protections but would also serve to deter noncompliance by care facilities.

Section 8: ***Severability***

The section is self-explanatory.

Section 9: ***No repeal nor preclusion.***

The section is also self-explanatory. Although existing rules of statutory construction in the state may make this section superfluous, out of an abundance of caution, this section is included to make clear that no other existing criminal offenses should be precluded or repealed by the adoption of legislation modeled after these guidelines. This is particularly true with respect to offenses not covered in the guidelines' definition of "abuse" or "exploitation." Obviously, existing laws in conflict with or supplanted by the guidelines should be specifically addressed.

GUIDELINES TO PROHIBIT PATIENT AND RESIDENT ABUSE

Sec. 1: ***Definitions*** -- As used in these guidelines, unless the context clearly indicates otherwise:

(1) "Abuse" means:

(a) Any assault as defined in [reference existing state law];

(b) Conduct which *inflicts/causes* or which is *likely to/could* produce physical *pain/injury/harm* to a patient or resident of a care facility, except where such conduct is a part of the treatment and care, and in furtherance of the health and safety of the patient or resident.

(c) Conduct which *inflicts/causes* or which is *likely to/could* produce psychological *pain/injury/harm* to a patient or resident of a care facility, except where such conduct is a part of the treatment and care, and in furtherance of the health and safety of the patient or resident.

(d) The failure to provide treatment, care, goods or services necessary to the health, safety or welfare of a patient or resident of a care facility.

(e) Failure to carry out a plan of treatment or care prescribed by the physician of a patient or resident of a care facility.

(f) The use of a physical or chemical restraint, medication or isolation as punishment, for staff convenience, as a substitute for treatment, in conflict with a physician's order, or in quantities which *preclude/inhibit* effective care or treatment.

(2) "Care Facility" means: Hospitals; skilled nursing facilities; intermediate care facilities; care facilities for the mentally retarded; psychiatric facilities; rehabilitation facilities; kidney disease treatment centers; home health agencies; ambulatory surgical or out-patient facilities; homes for the aged or disabled; group homes; adult foster care homes; private homes which provide personal care, sheltered care or nursing care for one or more persons; adult day care centers; and any other health or resident care related facility or home, whether publicly or privately owned.

(3) "Exploit" means: The expenditure, diminution, or use of the property or assets of a patient or resident of a care facility without the express voluntary consent of the patient or resident or the consent of a legally authorized representative of an incompetent patient or resident.

(4) "Knowingly" means: [as defined by existing state law]

(5) "Patient"means: Any person who receives treatment from a care facility.

(6) "Person" means: Any natural person, corporation, partnership, unincorporated association or other business entity.

(7) "Physical *pain/injury/harm*" means: [as defined by existing state law]

(8) "Psychological *pain/injury/harm*" means: [as defined by existing state law]

(9) "*Recklessly/Culpable negligence*" means: [as defined by existing state law]

(10) "Resident" means: Any person who resides in a care facility.

(11) "Serious physical *pain/injury/harm*" means: [as defined by existing state law]

Sec. 2: ***Offenses of patient or resident abuse and exploitation***

(1) No person shall knowingly commit abuse of a patient or resident of a care facility.

(2) No person shall *recklessly/through culpable negligence* commit abuse of a patient or resident of a care facility.

(3) Whoever violates subsections (1) or (2) of this section is guilty of the offense of patient or resident abuse.

(a) Violation of subsection (1) of this section which causes any serious physical *pain/injury/harm* is a felony of [set class or degree].

(b) Violation of subsection (1) of this section which causes any physical or psychological *pain/injury/harm* is a felony of [a lesser degree than (a) above].

(c) Violation of subsection (2) of this section which causes any serious physical *pain/injury/harm* is a felony of [the same degree as (b) above].

(d) Violation of subsection (2) of this section which causes physical or psychological *pain/injury/harm* is a felony of [a lesser degree than (b) above].

(e) Violation of subsections (1) or (2) of this Section which does not cause physical or psychological *pain/injury/harm* is a [*serious/aggravated* misdemeanor].

(4) No person shall knowingly exploit any patient or resident of a care facility.

(a) Violation of subsection (4) of this section is a felony [of the same degree as (3)(b) above].

Sec. 3: ***Reporting requirements***

(1) Any person, within the scope of their employment at a care facility or in their professional capacity, who has knowledge of or reasonable cause to believe that any patient or resident of a care facility has been the victim of abuse or exploitation as defined in these guidelines, or any other criminal offense, shall report or cause a report to be made of the abuse, exploitation, or offense.

(2) The reporting of conduct as set forth in subsection (1) shall be:

(a) made immediately upon discovery to the appropriate local law enforcement agency; and,

(b) made orally or telephonically within twenty-four hours of discovery to the [designated agency]; and,

(c) made in writing within two working days of discovery to the [designated agency] with a copy to be retained by the person making the report.

(3) The contents of the reports required by subsections (1) and (2) above shall contain the following information unless the information is unobtainable by the person reporting:

(a) the name, address, telephone number, occupation and employer's address/phone number of the person reporting;

(b) the name and address of the patient or resident who is believed to be the victim of abuse, exploitation or any other criminal offense;

(c) the details, observations, and beliefs concerning the incident;

(d) any statements relating to incident made by the patient or resident;

(e) the date, time and place of the incident;

(f) the name of any individual (s) believed to have knowledge of the incident; and

(g) the name of any individual(s) believed to be responsible for the incident and their connection to the resident.

(4) Any other individual who has knowledge of or reasonable cause to believe that any patient or resident of a care facility has been the victim of abuse or exploitation as defined in these guidelines, or any other

criminal offense, may make a report to the appropriate local law enforcement agency, and [the designated agency].

(5) (a) Any individual who, in good faith, makes a report as set forth in this section or who testifies in an official proceeding regarding matters arising out of this section shall be immune from all criminal and civil liability for such reporting or testifying.

(b) No individual shall be terminated from employment, demoted, rejected for promotion or otherwise sanctioned, punished or retaliated against by any person who, in good faith, makes a report as set forth in this section or testifies in any official proceeding regarding matters arising out of this section.

(c) No patient or resident shall be transfered, discharged, retaliated or discriminated against, or otherwise punished by any person because the patient or resident, in good faith, makes a report as set forth in this section or testifies in any official proceeding regarding matters arising out of this section.

(d) Any person who violates subsection (5)(b) or (5) (c) of this section shall be guilty of a misdemeanor.

(e) In addition to criminal sanctions under subsection (5)(d), the offending party shall be ordered to pay treble damages, costs, and attorneys fees to the offended party.

(f) Subsections (5)(a), (b) and (c) shall not apply to any individual who has engaged in the abuse, exploitation or other criminal conduct against the patient or resident at issue.

(6) Any privilege established by existing state law relating to exclusion of confidential communications and competency of witnesses may not be invoked in any criminal or civil action arising out of a report made pursuant to this chapter.

(7) (a) No person shall knowingly fail to make the report as required by subsections (1), (2) and (3) of this section.

(b) Violation of subsection (7)(a) is a misdemeanor [set class or degree]

(8) (a) No person shall knowingly:

(1) attempt, with or without threats or promises of benefit, to induce another to fail to report an incident of abuse, exploitation or other criminal offense pursuant to subsections (1), (2), and (3) of this section; or

(2) fail to report an incident of abuse, exploitation or other criminal offense after another has indicated a reliance on such reporting pursuant to subsection (1) of this section; or

(3) alter or change without authorization, destroy or render unavailable, a report made by another pursuant to subsections (1), (2), (3) and (4) of this section.

(b) Violation of subsection (8)(a)(1), (2) or (3) is a *misdemeanor/felony* [of a set class or degree higher than 7(b)].

(9) (a) These guidelines shall be posted in a prominent location in all care facilities. In addition, all employees, owners, operators, and health care providers who provide services in care facilities shall be required to sign an affidavit provided by the [designated state agency] attesting to the fact that they have read these guidelines. The care facility shall thereafter retain the signed affidavit.

(b) A facility that fails to comply with the provisions of subsection (9)(a) of this section shall be subject to a civil penalty in an amount not to exceed [appropriate monetary penalty].

Sec. 4: *Collateral consequences of conviction; mandatory revocation or suspension of license.*

(1) The conviction of any licensed or registered professional person or entity for any offense arising under these guidelines, including failure to report abuse, exploitation or any other criminal offense shall be reported by the clerk of the convicting court to the appropriate state board of licensure or registration. A certified copy of the judgement entered by the sentencing court shall be sufficient evidence of such conviction.

(2) The appropriate state board of licensure or registration shall suspend or revoke the license of the person or entity on account of such conviction for any period, including permanently, in its discretion, subject to the following mandatory minimum periods:

(a) In the case of a person or entity convicted of either the offense of abuse or exploitation as defined in these guidelines, the period of suspension or revocation of licensure shall be not less than three (3) years.

(b) In the case of a person convicted of failure to report as defined in these guidelines, the period of suspension or revocation shall be not less than six (6) months for a conviction in violation of subsection (7)(b) of Section 3 of these guidelines and shall be not less than twelve (12) months for a conviction in violation of subsection (8)(b) of section 3 of these guidelines.

(3) The mandatory suspension or revocation periods set forth in subsection (2) above shall also apply to any conviction of any licensed or registered professional person or entity for any offense not arising under these guidelines where the victim thereof is a resident or patient of a care facility.

Sec. 5: *Treatment in conformance to right to natural death.*

Any affirmative defense which may arise under [citation to "right to natural death" civil and criminal liability provision] pursuant to compliance with [citation to "right to natural death" procedures] shall be fully applicable to any prosecution initiated under these guidelines.

Sec. 6: *Treatment based on consent or religious belief*

To establish an affirmative defense under these guidelines, the defendant must prove either (a) and (c) or (b) and (c) below:

(a) That the act or failure to act was committed in accordance with the *written/informed* consent of the patient or resident or a person authorized to consent on behalf of the patient or resident,

(b) That the act or failure to act was committed in accordance with the wishes of the patient or resident or a person authorized to consent on behalf of the patient or resident, and was in accord with the tenets and practices of a recognized church or religious denomination;

(c) That the act or failure to act was in accord with existing state legal standards.

Sec. 7: *Civil cause of action*

(a) Notwithstanding any regulatory or administrative penalty and in addition to any private civil cause of action, the Attorney General is authorized to institute a civil cause of action against any person who fails to exercise reasonable care in the hiring, training, supervision, staffing or operation of any care facility when said failure results in the commission of abuse, exploitation, or any other crime against any patient or resident of a care facility.

(b) If the State establishes a failure by such person to exercise reasonable care as set forth in subsection (a) of this section, a penalty of not less than $10,000.00 shall be assessed by the court.

Sec. 8: *Severability*

The provisions of these guidelines are severable, and if any phrase, clause, sentence or provision of these guidelines, or the application of such phrase, clause, sentence or provision shall be held invalid, the remainder of these guidelines shall not be affected thereby.

Sec. 9: *No repeal nor preclusion*

Nothing contained in these guidelines shall be deemed to preclude prosecution under any other titles [of the State's criminal code] nor shall these sections be deemed to repeal any other sections [of the State's criminal code].

SENATE
STATE OF LOUISIANA

ALLEN R. BARES
State Senator
President of the Senate

P. O. Box 94183
Baton Rouge, LA 70804-9183
(504) 342-2040

July 21, 1988

The Honorable Claude Pepper
Chairman, Select Committee on Aging
Subcommittee on Health and Long-Term Care
377 House Office Building Annex 2
Washington, DC 20515

Dear Mr. Chairman:

I am in receipt of your letter dated July 5, 1988, concerning the status of funding for adult protective services in Louisiana's 1988-89 proposed budget.

As you know, Louisiana has experienced some major difficulties in terms of the state's revenues not growing proportionately to expenditures. As a result, many very important and needed programs have had to be either curtailed drastically or eliminated completely until such time that our revenue base is stabilized and funding is under control. To the extent possible, we have allowed the departmental executives to make the decisions of prioritizing within their budgetary units. They have effected savings where possible in order to meet the dollar level of resources we knew would be available for the new fiscal year.

In the case of the protective services program, the department felt that it was more important to provide those social services to the children of the state. Therefore, funding for adult protective services was requested as a decision package, i.e. predicated on funding at 100% of the Maximum Implementation Level. Unfortunately, since funding could not be provided at the 100% level, the adult protective services program has not been funded.

I share your concern for those Americans, regardless of age, who are abused. I feel that when the fiscal crises have passed and Louisiana is once again financially able to provide social services, programs such as protection of the vulnerable, adults as well as children, will be reinstated and funded.

Thank you for your concern of Louisiana's needy and your understanding of our fiscal difficulties. Hopefully, our difficulties will be short-termed and once again we will all be working toward our common goals.

With sincerest regards,

Allen R. Bares
President

State of Louisiana
OFFICE OF STATE INSPECTOR GENERAL
(504) 342-4262

BUDDY ROEMER
GOVERNOR

BILL LYNCH
INSPECTOR GENERAL

November 1, 1988

Mr. Peter Reinecke
Director of Research
U. S. House of Representatives
Select Committee on Aging
377 House Office Building Annex 2
Washington, DC 20515

FILE NO: 4-89-0029

Dear Mr. Reinecke:

Thank you for your letter and the enclosed documents concerning the elderly program.

I discussed this matter preliminarily with David Ramsey, Secretary of the Department of Health and Hospitals, which formerly was designated Health and Human Resources and incorporated this program.

The department has since been divided into DHH and the Department of Social Services (DSS), with the latter now handling the elderly program.

I am sending all of this material to Ms. May Nelson, who has been named Secretary of DSS, for her handling and response to your. If we can be of any further service, please advise. Thank you.

Very truly yours,

Bill Lynch

Bill Lynch
State Inspector General

BL/kd

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AN EQUAL OPPORTUNITY EMPLOYER

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Buddy Roemer
GOVERNOR

May Nelson
SECRETARY

December 7, 1988

Peter Reinecke, Director of Research
U.S. House of Respresentatives
Select Committee on Aging
Subcommittee on Health and Long-Term Care
377 House Office Building Annex 2
Washington, DC 20515

Dear Mr. Reinecke:

This letter is in response to your inquiry concerning the provision of Adult Protective Services in Louisiana.

The current SSBG Plan indicates Louisiana's desire and intent to provide protective services to children and adults. However, due to reduced state funds available to the Foster Care program, Louisiana felt compelled to establish as highest priority--services to children in the State's custody for protective reasons or those in danger of placement without intervention.

Louisiana's action to significantly reduce protective services to adults has been widely publicized through the normal budget approval process as well as discussion with Federal and State Legislators, local officials and private citizens.

As Secretary of the Department of Social Services, I strongly agree with your statement that adult protective services are vitally important. For this reason I ordered that a study, to include regional meetings throughout the State, be completed in cooperation with other State Departments and Agencies concerned with services to adults. This study was to determine the components of a comprehensive adult protective program and what it would cost to implement such a program. This study has been completed and the results will be included in the Department of Social Services budget request for 89-90. We plan to implement a comprehensive program of Adult Protective Services as soon as possible.

We appreciate your interest and concern for the welfare of Louisiana's elderly citizens.

Sincerely,

May Nelson

May Nelson, Secretary
Department of Social Services

MN:DC:kcb

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Regional Office VI
1200 Main Tower Building
Dallas TX 75202

October 19, 1988

Mr Peter Reineche
U.S. House Committee on Aging
377 House Annex 2
Washington, D.C. 20515

Dear Mr Reineche,

The purpose of this letter is to transmit to you the information regarding the Louisiana Title XX Block Grant, as requested in telephone conversation with Ralph Rogers, of my staff. Enclosed are copies of the essential pages of the current Louisiana Annual Social Services Program Plan for 1989.

As we receive additional information on the status of the State Plan and any amendments thereto we will keep you informed.

Sincerely,

William Acosta

William Acosta
Regional Administrator

Enclosure

FINAL
TITLE XX BLOCK GRANT
ANNUAL SOCIAL SERVICES PROGRAM
FOR THE
STATE OF LOUISIANA

Buddy Roemer, Governor
Chief Executive Officer of the State

Department of Health and Hospitals
Designated State Services Agency

David Ramsey, Secretary
Department of Health and Hospitals

State Fiscal Year July 1, 1988 - June 30, 1989

TABLE OF CONTENTS

Cover Page i

Introduction ii

Chapter I. SOCIAL SERVICES BLOCK GRANT PROGRAM IN LOUISIANA 1
- Goals 1
- Limitations on Use of SSGB Funds 2

Chapter II. INDIVIDUALS TO BE SERVED 3
- Eligibility 3
  - Need 3
  - Eligible Categories 4
  - Sliding Fee Scales 5
  - Special Eligibility 6
  - Eligibility Determination 7
  - Confidentiality 8
  - Purchase of Service (POS) Contracts 8
  - Direct Delivery Service Locations 8
  - OCS/DCYFS Regional Offices 12

Chapter III. SERVICES 13
- Adoption 13
- Child Protection Investigations 14
- Counseling 16
- Day Care for Children 17
- Family Services 18
- Foster/Residential/Placement Services 20
- Homemaker 22
- Information and Referral 23
- Protection for Adults 24
- Respite Care 26
- Socialization 27
- Training and Treatment 28
- Transportation 29

Chapter IV. FUNDING 30
- Funding Resources 30
- Table A - Title XX SSBG and State Funding Estimates of Statewide Expenditures by Service 1988-89 31
- Priorities for Services Provision 32
- Previous Year's Estimated Service Program Expenditures 33

Chapter V. POST EXPENDITURE REPORTS FOR 1985-86 AND 1986-87 34

Chapter VI. PUBLIC REVIEW PROCESS 36

Chapter VII. NON-DISCRIMINATION IN SERVICE DELIVERY 37

Selective Activities

1. Operation of TTY telephone equipment for hearing impaired clients
2. Operation of an automated telephone system to provide recorded informational messages

Federal Goals: I, II, III, IV, V

State Objective: To assist individuals requesting emergency assistance to locate, access and utilize Title XX and related services

Eligible Categories: WRI: All persons

Method of Delivery: Direct - Requests for emergency assistance. Cost is absorbed by all services.

SERVICE: PROTECTION FOR ADULTS

Definition: Therapeutic intervention on behalf of individuals age 18 years or older and emancipated minors, who are in danger, or threatened with danger, of physical or mental injury, neglect, self-neglect, maltreatment or exploitation including victims of family violence.

Note: Louisiana Revised Statute 14:403.2 is the legal basis for the State providing protection for adult services without the consent of those served if the adult is abused or neglected by a caregiver. The adult who self-neglects may voluntarily participate in the program after completion of a mandatory investigation.

Mandatory Activity: Case Management including investigations of all reports, assessment of need for this service, arrangements for utilization of this and other needed services, referrals and follow-up

Selective Activities (one or more):

1. Determination as to whether the report is valid and determination if the situation is caused by a caretaker or if the situation is a result of self-neglect
2. Arrangements for medical, psychological and/or psychiatric evaluations, as an integral but subordinate part of this service, when not otherwise available but necessary to assess or substantiate circumstances of injury, neglect, self-neglect, maltreatment or exploitation and such diagnostic information is needed to make referral to another appropriate agency or facility
3. Development and implementation of a goal oriented, time-limited service plan specifying needed services

4. Referral for legal assistance when individual is deprived of rights

5. For caregiver-type cases, referral to legal authorities for possible court action when extrajudicial means fail to correct the situation. Court alternatives include mandatory counseling, removing the adult and placing in alternative custody, adult foster care, or state custody, enjoining the contributing parties or providing for a medical examination or psychiatric/psychological evaluation to determine the least restrictive setting

6. Petition for interdiction pursuant to Civil Code Article 389 through 426 for those adults who self-neglect and present a danger to themselves or to others

7. Arrangements for homemaker services, adult day care and medical appointments and home health maintenance

8. Arrange for voluntary alternative living arrangement

9. Individual, family and group counseling supportive to the delivery of this service

10. Referrals for ancillary services - Title XVIII, Title XIX, Public Assistance, Food Stamps, Social Security benefits, etc.

11. Short term emergency shelter care, up to 30 days in any six month period, when the need is documented by state or provider agency personnel (30 days may be consecutive or may accumulate over more than one stay)

12. Arrangements for medical examinations and services, when not otherwise available, in emergent situations to alleviate pain and suffering, as an integral but subordinate part of this service

13. Arrangements for or provision of transportation and/or homemaker service, when necessary to the delivery of this service and not otherwise available

Federal Goal: III

State Objective: To eliminate, remedy, halt or hinder the progression of the conditions which constitute harm or threat of harm to adults

Eligible Categories: WRI: All adults who are determined to be in need of this service by the provider. Individuals whose need for protection is documented by state personnel are also eligible for all other needed services defined in this plan and appropriate to adults.

Method of Delivery: Direct: Excludes victims of Family Violence
Purchased: Reportable Unit of Service: One Unit per-day per primary client with regards to one, or any combination, of the selective activities, or one unit per overnight stay in shelter

CHAPTER IV

FUNDING RESOURCES

Public Law 98-135 enacted October 24, 1983 increased the authorization for SSBG appropriation from $2.5 billion to $2.7 billion for FFY 84 and each succeeding year. Federal Register, Vol. 51, Number 226, Monday November 24, 1986 specifies the amount of $50,396,171 as Louisiana's allotment for federal fiscal year 1988. Federal Register, Vol. 53, No. 22, Wednesday, February 3, 1988 specifies the amount of $50,134,992 as Louisiana's allotment for federal fiscal year 1989. SSBG funds are available to the state for expenditure in the federal fiscal year appropriated and in the following federal fiscal year.

Estimated SSBG program expenditures for July 1, 1988 through June 30, 1989 are as follows:

Federal	$50,200,287	
LIEA	1,042,273	
TOTAL	$51,242,560	Program Amount

The appropriation and allocation of funds according to this plan is subject to legislative and gubernatorial approval as well as the availability of federal and state funds. All requests for funding from private providers are subject to competition.

Following is Table A which reflects the anticipated expenditures of SSBG and state funds by service area for direct and purchased services. The delivery of services derived from multiple funding sources, and the administration of those service programs, are costs to the Social Services Block Grant.

TABLE A
ESTIMATES OF EXPENDITURES BY SERVICE AREA FOR PROGRAM YEAR 1988-89
METHOD OF DELIVERY: DIRECT AND PURCHASED
FUNDING SOURCES: SSBG AND STATE

SERVICE	EXPENDITURES
Adoption	$ 3,246,826
Child Protection Investigations	11,369,701
Counseling	46,750
Day Care for Children	9,539,899
Family Services	11,003,817
Foster/Residential/Placement Services	16,966,228
Homemaker (purchased only) *	374,593
Information and Referral	**
Protection for Adults	711,258 *
Respite Care	1,271,380
Socialization	8,075
Training/Treatment	208,278
Transportation	424,452
TOTAL	55,171,257

Estimated SSBG:...$51,242,560
State:... 3,928,697

* Direct delivered homemaker costs are included in the service areas of Child Protection Investigations, Family Services, Protection for Adults, and Foster/Residential/Placement.

** Cost is absorbed by all services.

PRIORITIES FOR SERVICES PROVISION

Beginning in March 1981, in anticipation of the passage of Public Law 97-35, the state's planning for the provision of services based on the following categories of priority:

Priority 1. Life Support - those services which if denied would place individuals at life threatening risk.

Priority 2. Essential services, although non-life support, which maintain individual health and support the family unit.

Priority 3. Those services which are important but do not meet the criteria of 1 and 2 above or are available from another source.

As described in this plan, social services delivered and/or purchased by OCS are prioritized as follows:

1. Protective Services for Children and Adults (Child Protection Investigations, Family Services, Protection for Adults)
2. Foster/Residential/Placement Services and Adoption
3. Day Care for Children
4. Transportation
5. Homemaker
6. Respite Care
7. Information and Referral (for emergency assistance)
8. Counseling
9. Training/Treatment
10. Socialization

In determining its priorities OCS has taken into consideration its legislative mandates to provide certain services. LA Revised Statute 36:258(G) specifies that OCS provide Protective Services, Foster Care, Adoption, Day Care, and Client Placement. This Act also specifies that OCS provide related services for persons dependent, neglected, abused, disabled, blind and elderly, with the exception of those programs and services assigned to the Office of Elderly Affairs in the Governor's Office.

Additional legislation also addresses state responsibility for specific services as follows:

Protection for Children -
LRS 14:403 and LRS 46:51(16)

Foster Care -
LRS 46:51(8)

Adoption -
LRS 9:427 and LRS 46:1790 - 1973

Information and Referral -
LRS 46:448

Protection for Adults -
LRS 14:403.2